

CHRONIC PAIN:

THE FUNCTIONAL RESTORATION PROGRAM,

POLICIES and LEGISLATIVE PROVISIONS

Background Paper For the Statutory Review Committee

Workers' Compensation Board of Nova Scotia
Corporate Policy, Planning & Evaluation Department

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1.0 EXECUTIVE SUMMARY

The *Workers' Compensation Act* (Chapter 10 of the Acts of Nova Scotia 1994-95), introduced February 1, 1996, is currently under review by a committee struck by the Governor in Council for this purpose. One of the mandated topics, as outlined in the terms of reference, under review is the chronic pain-related legislative provisions, policies and program. This paper provides information to address Question # 15 in the terms of reference: What has been the impact of the *Functional Restoration (Multi-Faceted Pain Services) Program Regulations*, and the WCB's chronic-pain program, including its rehabilitation aspects?

The first legislative provisions for chronic pain were proclaimed in March 1996 but retroactive to February 1, 1996 and were contained within the *Functional Restoration (Multi-Faceted Pain Services) Program Regulations*. The following month, in April of 1996, the Board of Directors for the Workers' Compensation Board of Nova Scotia (WCBNS) approved its first chronic pain policies. Prior to this period, the WCBNS did not provide permanent benefits for chronic pain unless it could be demonstrated that the worker had significant objective physical findings but there were no formal provisions nor current scientific evidence for the practice. Chronic pain was not well understood in the medical and scientific community and its treatment and management were equally controversial. Pressure to deal with this issue in the early 1990's was applied by the Committee on Public Accounts of the Nova Scotia Legislature, the Standing Committee on Human Resources along with the public's response to some decisions from the external Workers' Compensation Appeal Board which provided permanent benefits for chronic pain. The WCBNS commissioned Dr. J. Murray in 1994 to research this issue and provide a report and recommendations outlining the nature, treatment and management of chronic pain. The *Regulations* and related policies, drafted in accordance with Dr. Murray's scientific findings, provided a definition of chronic pain and limited the benefits for chronic pain to those provided under the Functional Restoration Program (FRP) – a time limited program consisting of multi-faceted services and short term, but no long term, financial assistance.

The *Workers' Compensation Act* ("the Act") was amended in April 1999 with the introduction of *An Act to Amend Chapter 10 of the Acts 1994-95* ("Bill 90"). *Bill 90*, among other changes, provided the following: a definition of chronic pain; clarification that workers injured prior to March 23, 1990 (the date of the Supreme Court of Nova Scotia's *Hayden* decision which ruled that benefits for permanent disabilities should be calculated on an earnings-loss rather than on the then existing clinical rating system – a significant departure from the way long term earnings had been provided) and who had chronic pain were not eligible for long term disability benefits; the provisions for extended benefits for eligible workers with chronic pain injured between March 23, 1990 and February 1, 1996 (this period has become known as the "window" or "transition" period); and clarified that workers with chronic pain injured on or after February 1, 1996 were entitled only to the benefits provided within the *Functional Restoration Program Regulations*.

When the FRP was approved in 1996, the Board of Directors stipulated that a program evaluation be conducted in three years at which time a decision would be made whether to continue the program and if so determine what changes, if any, were required. The evaluation was completed as directed and the results were presented to the Board of Directors in November of 1999. Overall, the results of a telephone survey of injured workers who participated in the FRP demonstrated that the FRP generally benefited workers by helping to prevent the development of chronic pain and by assisting injured workers manage their chronic pain once it developed. The majority of program participants reported satisfaction with the services provided through the FRP. Staff and psychologists were surveyed through a self-completion mail survey. The results indicated they were also satisfied with the FRP, agreed that the FRP assisted injured workers, were supportive of the continuation of the FRP and made suggestions for administrative changes. The Board of Directors considered the evaluation results and approved the continuation of the FRP in its December 1999 meeting, with the understanding that the noted administrative changes were to be implemented.

The FRP and the chronic pain provisions of the *Act* were determined to be unconstitutional on January 31, 2000 in two Workers' Compensation Appeals Tribunal (WCAT) Panel decisions. These decisions effectively suspended the FRP and related policies until November 8, 2000 when the two WCAT

decisions were overturned in one comprehensive decision of the Nova Scotia Court of Appeal (NSCA). The FRP was then reinstated. Leave to appeal the NSCA's decisions was granted in both by the Supreme Court of Canada (SCC) on June 14, 2001. Final decisions from the SCC regarding these chronic pain provisions and *Regulations* are not expected until early 2003. In the interim, the WCBNS continues to apply the chronic pain sections of the *Act* and the *FRP Regulations* as confirmed by the NSCA.

2.0 INTRODUCTION

The *Workers' Compensation Act* (Chapter 10 of the Acts of Nova Scotia 1994-95) is currently under review by a committee appointed by the Governor in Council. The committee is operating within the terms of reference, set out by the Governor in Council, which determined the method, timelines and specific sections of the *Act* to be reviewed. This paper provides information to address Question # 15 outlined in the committee's terms of reference:

What has been the impact of the *Functional Restoration (Multi-Faceted Pain Services) Program Regulations*, and the WCB's chronic-pain program, including its rehabilitation aspects?

The intent of this paper is to provide the Statutory Review Committee with information about the provisions, offered through the Workers' Compensation Board of Nova Scotia (WCBNS), for injured workers who may develop, or have developed, chronic pain. First, the key steps which took place during the period of 1990 to 1996 and led to the first legislative provisions for chronic pain are outlined. This is followed by a description of the Functional Restoration Program (FRP), initiated in 1996, for injured workers who may develop or have developed chronic pain. The program was established with the understanding that it would be evaluated three years' after its inception. The evaluation was carried out in 1999 and a summary of the methodology, the findings and recommendations are presented in this paper. Next, a description of the activities associated with the implementation of the evaluation recommendations is provided. Finally, the various legal decisions impacting the legislative and policy provisions for claims involving chronic pain, including the current legal challenge to the Supreme Court of Canada, are described.

3.0 DEVELOPMENT OF THE FUNCTIONAL RESTORATION PROGRAM

3.1 Establishment of Chronic Pain Policies and the Functional Restoration Program.¹

Establishment of Chronic Pain Policies and the Functional Restoration Program

Prior to March 23, 1990 the Workers Compensation Board of Nova Scotia paid permanent disability benefits using a clinical rating system. The clinical rating system did not consider the impact of the injury on a person's ability to return to work. A significant Supreme Court of Nova Scotia decision, known as the *Hayden* decision¹, rendered on March 23, 1990, changed the way that benefits for permanent disabilities were provided to injured workers in Nova Scotia. In the *Hayden* decision, the Court ruled that benefits for permanent disabilities should be calculated on an earnings loss rather than a clinical rating system. This decision led to an interim period, also known as the "window" or "transition" period, which bridged the period marked by the end of the Former Act (*Workers' Compensation Act*, R.S.N.S. 1989, Chapter 10) and the full implementation on February 1, 1996 of the new *Workers' Compensation Act*. Under the "Former Act" the Workers' Compensation Board of Nova Scotia (WCBNS) did not provide permanent disability benefits for those workers who had chronic pain. During the "window" period, workers who were denied benefits for chronic pain sought reversal of their compensation decisions by appealing their cases to the former Workers' Compensation Appeal Board (WCAB). Some of these appeals were accepted and awards for permanent pensions for chronic pain cases were provided.

Initially the WCAB did not have clear criteria for dealing with chronic pain claims. In May 1994 the WCAB rendered Decision 93-165 that adopted the criteria established in a decision of the Ontario Workers' Compensation Appeals Tribunal, known as Decision 915. However, the WCBNS did not recognize chronic pain as a compensable condition and there was no legislation specifically related to compensation for chronic pain.

¹ *Hayden v. Workers' Compensation Appeal Board* (No. 2) (1990) 96 N.S.R. (2d) 108 (S.C.A.D)

In order to better understand and resolve the issue of chronic pain, the WCBNS contracted Dr. T. J. Murray² in 1994 to conduct a literature review and to write a discussion paper on his findings. The overall goal of the study was to assist the WCBNS Board of Directors and the public to better understand the nature, prevention and treatment/management of chronic pain, and the nature and extent of the connection, if any, between chronic pain and the workplace.

Dr. Murray submitted a draft report to the WCBNS for distribution to stakeholders and discussion in November 1994. Over 100 copies of the draft report were sent to stakeholders including members of the medical community, labour and business organizations, injured workers' groups, and other health professionals. Stakeholders were invited to comment on the report and 20 written responses were received. There were generally very favourable responses received from all stakeholders.

Dr. Murray submitted his final report, entitled *Chronic Pain*, to the Board of Directors of the WCBNS in February 1995. In this report, the term "pain" was defined,³ a differentiation made between acute pain and chronic pain, the prevalence of chronic pain determined and the complexity of the condition were outlined. The paper's findings revealed that physical, emotional, behavioral, social and cultural factors were involved in the development of chronic pain. The need for better treatment and management of chronic pain patients was identified: including the concept of prevention of chronic pain, the philosophy of rehabilitation (early intervention, increased activity, improved function, early return to work) and the use of normal recovery times for illness and injury. Dr. Murray stressed the goals of increased activity and the need to improve function and the goal of early return to work even in the presence of pain. A multi-disciplinary approach for the treatment of chronic pain and an evaluation of this treatment approach were recommended.

Dr. Murray emphasized the need for education of physicians and other health care professionals about the nature and management of acute versus chronic pain along with the education of employers and co-

2 Dr. Murray is a pre-eminent pain researcher and Director of the Dalhousie University MS Research Unit, former Head of the Division of Neurology, Chief of Medicine at Camp Hill Hospital and Dean of Medicine at Dalhousie University.

3 Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of tissue damage. The International Association for the Study of Pain LaRocca, 1992.

workers to improve the return to work of injured workers with chronic pain. He stressed the need for employers to accommodate the worker returning to the workplace since the likelihood of return to work and a full and active life diminishes the longer the worker remains off work. Further, Dr. Murray outlined the need for the development of practice guidelines and a handbook on the management of chronic pain. Finally, clarification of the workers' compensation process was recommended as well as the need for clear, simplified and widely understood policies and procedures related to chronic pain (Murray, 1995).

Dr. Murray reiterated the main findings of Spitzer's earlier (1993) Quebec Task Force Report regarding the management of back pain and indicated these findings could be generalized to the chronic pain patients discussed in his report (p.9):

- *Workers with chronic pain should be strongly urged to return to work almost immediately if there are no objective signs found by the clinician who only needs a good history and physical examination to classify the type of problem and decide on its management.*
- *Pain alone is an insufficient cause to delay resumption of work.*
- *The few patients failing to respond to conservative management should be followed up progressively with standardised diagnostic packages and forceful treatment programs that minimise absenteeism.*
- *Our current health system and employer attitudes which encourage a drift towards sick leave for workers with chronic pain should have their strategies radically altered to prevent chronicity.*
- *Everything we do as clinicians for patients with chronic pain should be evaluated, or re-evaluated, by well designed and properly executed randomised controlled trials that carefully assess the results of our treatments. The study subjects should be patients and the priority outcome should be return to work.*

Acting on the findings and recommendations in the Murray Report, the WCBNS Board of Directors approved a list of assumptions which were the basis for the development of its approach to chronic pain. These assumptions are outlined below:

- (1) Chronic pain is multi-causal in nature, and involves complex physical, emotional, psychological, behavioural, social and cultural factors.
- (2) Pain (both acute and chronic) is personal and subjective. There is no uniform or "correct" response, and each worker will respond to pain and injury in his or her individual way. In most cases, there will be no objective medical evidence of the presence of pain, or of its intensity.
- (3) Acute pain and chronic pain are different, and should be managed and treated differently. Chronic pain is complex and multifaceted, and does not usually respond well to the treatments traditionally prescribed for acute pain.
- (4) Once an acute injury has healed, and there is no risk of re-injury, a worker will benefit from improving his or her function despite continuing pain.
- (5) Injury prevention and early appropriate management of soft tissue injuries is more effective than a process of dealing with chronic pain after it has occurred.

The WCBNS Board approved a discussion document, based on the above assumptions, entitled *Chronic Pain: Options for Discussion* (1995). The document was distributed to 241 stakeholders for comment in August 1995. Written responses were received from 14 individuals. There was general agreement among respondents with, and support for, the assumptions listed in the paper. However, a few physicians and health care professionals who responded in writing to the discussion document argued that objective evidence should not be a necessary prerequisite to a claim for permanent compensation benefits and they suggested that pain should be regarded as an impairment. Employers and employer organizations did not agree with this interpretation and suggested that pain on its own should not be considered an impairment.

The WCBNS furthered its efforts to understand chronic pain. It reviewed current medical literature and new developments in disability management with respect to chronic pain and similar conditions. Also, in the spring of 1995, the Board of Directors and key staff attended a conference on management of chronic pain sponsored by the Ontario Institute for Work and Health. They received a presentation on the chronic pain policies and practices of all other Canadian jurisdictions and were briefed on two key

relevant studies regarding chronic pain.⁴ In December of 1995 the Board of Directors reviewed further research on the issue of chronic pain syndrome. They were presented with and considered options for the prevention, management and compensation of chronic pain. After extensive review and discussion, the WCBNS Board requested that staff of the WCB develop the time-limited functional restoration program for chronic pain and like conditions, and decided that permanent impairment benefits should not be awarded to workers with chronic pain.

In 1995, the Nova Scotia House of Assembly's Public Accounts Committee and Standing Committee on Human Resources along with the former Minister of Labour requested clarity on the issue of chronic pain and identified the need for the Workers' Compensation Board of Directors to develop a policy to deal regarding chronic pain.

The WCBNS's efforts to address the issue of chronic pain culminated in a policy discussion paper entitled *Strategy for Work Related Injuries Where Pain Beyond Normal Healing Time Becomes a Barrier to Work* which was circulated to Board Members for discussion at their January 12, 1996 meeting. The chronic pain policies outlined in the document essentially provided the Functional Restoration Program (FRP) for the prevention and management of chronic pain but did not provide permanent medical impairment benefits. The FRP was designed to deliver timely and appropriate rehabilitative services to prevent the chronicity of pain and promote the early return to work. The ultimate goal of the FRP was to assist injured workers experiencing chronic pain to return to work as safely and as soon as possible. The Board approved the chronic pain policies and the FRP. The FRP was proposed as a three-year pilot program. The program was to be monitored on a yearly basis with a mandatory comprehensive evaluation at the end of the third year at which time a decision to continue, expand, modify or rescind the FRP would be made. A motion was passed at the January 1996 Board meeting to approve in principle the chronic pain policies and the FRP, along with the need to create a regulation enabling WCBNS to implement the FRP.

4 *Back Pain in the Workplace: Management of Disability in Nonspecific Conditions*, the 1995 report of the Task Force on Pain in the Workplace prepared by the International Association for the Study of Pain; and *Acute Low Back Pain in Adults: Assessment and Treatment*, US Department of Health and Human Services, Agency for Health Care Policy

In March 1996 legislation was proclaimed to specifically address the issue of chronic pain, effective February 1, 1996. *The Functional Restoration (Multi-Faceted Pain Targeted Services) Program Regulations*, Order in Council 96-207, explicitly exclude chronic pain from Part I of the *Workers' Compensation Act: Chapter 10 of the Acts of 1994-1995* ("New Act") except in accordance with these regulations, which provide FRP services and a limited period of earnings-replacement benefits for those workers with chronic pain.

The chronic pain policies approved in the January 1996 Board of Directors meeting were subsequently modified to conform with the *Functional Restoration Regulations* and approved in the April 1996 Board meeting.

3.2 Definition of Chronic Pain.3 Definition of Chronic Pain

Chronic pain is defined in Section 10A of the *Act* and the *Functional Restoration (Multi-Faceted Pain Targeted Services) Program Regulations* as pain

- (a) continuing beyond the normal recovery time for the type of personal injury that precipitated, triggered or otherwise predated the pain; or

- (b) disproportionate to the type of personal injury that precipitated, triggered or otherwise predated the pain,

and includes chronic pain syndrome, fibromyalgia, myofascial pain syndrome, and all other like or related conditions, but does not include pain supported by significant, objective, physical findings at the site of the injury which indicate that the injury has not healed.

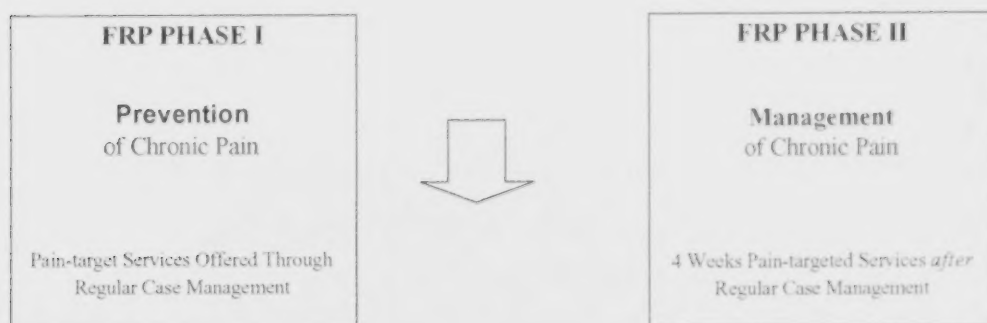
Compensation is provided for pain which is supported by significant, objective, physical findings.

3.3 Description of the Functional Restoration Program.4 Description of the Functional Restoration Program

The FRP is defined as a pro-active program established by the *FRP Regulations*⁵ and designed to assist workers in preventing and managing chronic pain. The objective of the FRP is to manage the pain and pain-related symptoms as the factors limiting a return to work. It is offered, in addition to, regular case management activities to eligible workers identified as potentially benefiting from the services of the program (*Glossary of WCBNS Policy Manual*, 1999, p. 10).

The FRP is a time-limited two-phased program characterized by the timely and appropriate delivery of rehabilitation services for workers who are perceived by the WCBNS Case Worker providing disability case management services as being at risk of chronicity.⁶ Overall the program aims to limit the impact of pain as a barrier to return to work and at promoting an early return to work. The program is based on the philosophy of Early Assistance and the principles of Disability Case Management.⁷ Essentially Early Assistance requires the provision of appropriate services at the appropriate time and with the need for a pro-active rehabilitation approach. Disability Case Management establishes the need for a return to work goal and focuses on the necessary rehabilitation required to reach that goal (see Figure 1).

Figure 1. The Functional Restoration Program



⁵ The *FRP Regulations* relate to Phase II of the FRP: the management of chronic pain. Reference is also made to the FRP in WCB Policies 2.4.1R to 2.4.7.

⁶ This section provides a description of FRP as outlined in the original document and approved in the January 12, 1996 Board of Directors meeting. FRP has undergone minor changes since it was originally approved.

⁷ These principles are outlined in two documents: (1) *Early Intervention for Recovery and Re-Employment Background Paper* (Connell, K., 1993) and (2) *Early Intervention Companion Document: Vocational Rehabilitation Strategy* (Connell, K., 1993).

The primary goal of Phase I of the program is the prevention of chronic pain through the identification of workers for whom pain is, or has the potential to be, a barrier to return to work. Phase I of the FRP is intended to be offered as part of the disability case management action plan but with the addition of the pain-targeted services to enable the worker to return to work. Before FRP Phase I is offered, the Case Worker is to consult with the Program Manager, Health Care Benefits and the Administrator of Medical Services.⁸ The pain-targeted services include, but are not limited to, psychological assessment and counselling specific to pain behaviour. Pain targeted services are capped at a maximum of 12 psychological sessions and a total cost \$2000.00 per worker. Pain targeted services may also include chiropractic, physiotherapy, work conditioning and work hardening. Participation in the FRP is voluntary and has no impact on any applicable case management or benefit entitlement decisions (Appendix A. Policy 2.4.1R).

The goal of FRP Phase II is the management of chronic pain. This phase is offered to workers who, despite appropriate case management and after completing FRP Phase I, continue to experience pain as a barrier to return to work, in the absence of significant objective physical findings or pathology related to the injury. The program involves services which are multidisciplinary in approach, as in Phase I of the FRP, and may include work conditioning, work hardening, psychological counselling, chiropractic, physiotherapy and education. The program does not guarantee a return to work or the elimination of pain but may include specific goals such as: a reduction in medication usage; addressing psychological issues; improved understanding of the role that emotions, behaviours and attitudes play in chronic pain; encouragement of healthy behaviour, while reducing reward for pain behaviour; and improvement in the level of function in social, familial, household or occupational roles. Phase II of the FRP is intended for workers who are within 12 months of the date of their injury (Appendix B. Policy 2.4.2)

⁸ This was the FRP approval process outlined in 1996 but it has since been modified based on the 1999 evaluation findings outlined in a subsequent section. The current referral procedure has been revised to enable Case Workers to offer timely pain prevention and management services for injured workers. Consultation with a Medical Advisor is required for FRP Phase II to ensure that appropriate injured workers are referred for the final phase of the program.

Phase II is limited to four weeks duration and is capped at \$8000.00 per worker (Appendix C. Policy 2.4.3). If the worker is beyond 12 months of the date of their injury, they may be offered FRP I (where it is determined that additional case management services are warranted) or FRP II where the worker: (1) has been assigned a permanent medical impairment rating by the Board before February 1, 1996; (2) has not yet received a permanent award from the Board; and (3) has an earnings loss as a result of the compensable injury (Appendix D. Policy 2.4.4).

3.4 Expected Incidence of Chronic Pain Cases per Year.5 Expected Incidence of Chronic Pain Cases per Year

At the time of launching the FRP, the projected number of workers at risk of developing chronic pain was estimated to be approximately 1000 per annum. It was further estimated that approximately one half (i.e. 500 per year) of those who received Phase I would also require Phase II of the FRP.⁹ The actual number of injured workers who participated in the program was lower than expected – approximately 120 per year in the first three years after its implementation.

3.5 Implementation of the FRP .0 IMPLEMENTATION OF FRP

There were two major initiatives related to the implementation of FRP: the training of WCB staff and the training of psychologists.

The initial training of case management staff (all staff dealing with time loss claims that require adjudication, case management or that are in the appeal system: Client Service Managers, Medical Advisors, Case Managers, Vocational Rehabilitation Counsellors, Adjudicators, Hearing Officers, and the Case Review Committee) occurred throughout March and April of 1996. One hundred participants in total attended one of the eight two-day sessions during this time. In addition, two follow-up sessions

⁹ These projections were based on a document entitled *Methodology Costing Chronic Pain* (1996).

were offered: the first was held in September 1996 to address the topic of normal recovery times followed by a one-day session (offered to all Client Services staff) conducted by Dr. Myles Genest between May and October of 1997 on the nature of psychological services.

The second major FRP implementation activity was the identification and training of psychologists. All psychologists who were listed either in the Private Practice Directory, Association of Psychologists of NS or in the Directory of Psychologists, Nova Scotia Board of Examiners in Psychology were sent a letter along with a self-completion survey. WCBNS staff reviewed the completed surveys, identified those who met the established criteria, and the Program Manager and Administrator of Medical Benefits gave final approval for psychologists to offer FRP psychological counselling services. Training of service providers occurred in July of 1996. The one-half day sessions took place in Halifax, Sydney, Truro and Bridgewater.

In addition to staff and service provider training, information regarding the FRP was sent to all physicians, physiotherapists and chiropractors in Nova Scotia in 1996. April 1999 marked the third anniversary of the FRP and the need for an evaluation as determined by the Board of Directors when the program was initially approved in 1996.

4.0 EVALUATION OF THE FRP

4.1 Preliminary Evaluation Analysis

An analysis was conducted to identify the stakeholders who had a direct interest or involvement in the program. From this analysis, it was determined that the key stakeholders included (1) FRP participants, (2) psychologists who offered FRP psychological counselling, and (3) staff who referred injured workers to the program. Employers were considered a key stakeholder but there was concern that they may not be able to evaluate the program since they likely would have indirect and therefore limited experience with the program. While other pain-related services are offered in the FRP, they are also offered through normal case management and it was determined that the evaluation should concentrate on services unique to the FRP.

The major evaluation question that needed to be answered, as mandated by the Board of Directors, was *Should the WCB continue to offer the FRP and if so what changes are required?* Other evaluation questions were identified and are summarized in Table 1.

Table 1. FRP stakeholders, evaluation questions, and methodology.

Stakeholder	Evaluation Question	Methodology
Workers	Are workers satisfied with the program?	Telephone survey (external company to conduct survey)
	Did the program help participants deal with their pain?	
	Did the program prevent chronic pain?	
	Did the program assist workers with the management of chronic pain?	
	Did the program improve workers' function?	
	Did the program reduce workers' utilization of drugs?	
	Did the program provide information regarding roles that emotions, behaviours and attitudes play in chronic pain?	
	Did the program assist workers return to work?	
Psychologists	Did the program prevent and/or assist injured workers manage chronic pain?	Self-completion survey
	Did the program help workers address psychological issues related to chronic pain?	
	What changes are required for the FRP?	
WCB Staff (Adjudicators , Case Managers, Adjudication Advisors, Medical and Vocational Rehabilitation Counsellors)	What did some workers not accept FRP services and why did some workers not complete the FRP?	Self-completion survey (internal)
	Were workers willing to accept FRP services or was there resistance because of its psychological basis (stigma attached with psychological counselling)?	
	Were appropriate FRP services available to all injured workers who were identified as in need of FRP (or were there regional disparities)?	
	Were workers identified for Phase I & II in a timely manner?	
	Were workers offered Phase I & II at the appropriate time?	
	What barriers, if any, impacted on the offering FRP services?	
	Was the program viewed as user friendly?	
	Was staff comfortable offering a psychological intervention?	

Stakeholder	Evaluation Question	Methodology
	Did the program help workers address psychological issues related to chronic pain?	
	Did staff receive FRP training?	
	Do staff require more FRP training?	
	Does the approval process for FRP require streamlining?	
	How did the FRP approval process impact program implementation?	
	What changes to FRP are recommended?	
	Did service providers offer appropriate services to workers?	
	Why are the referral/ utilization rates for Phase I & II lower than predicted?	
	Could the capturing of the data be improved?	
	Did the service providers feel they received adequate training?	
	What did some workers not accept FRP services and why did some workers not complete the FRP?	

4.2 Evaluation Results

4.2.1 Overview of Evaluation Results

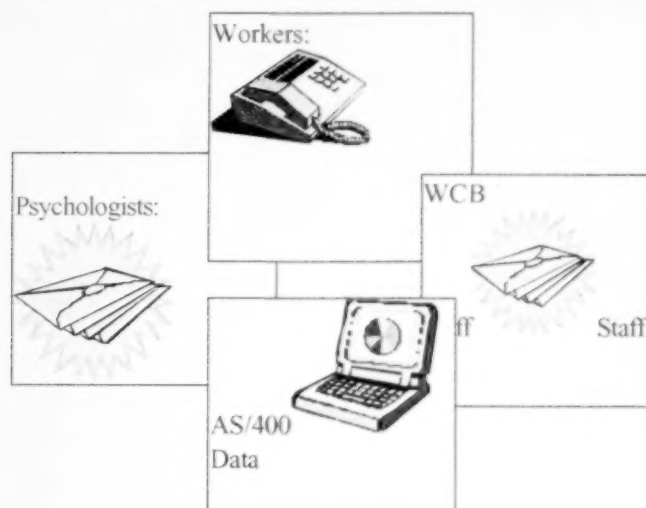
The FRP evaluation results demonstrated that the program generally benefited workers though there was a need to make some administrative modifications to enhance its potential. The majority of workers, psychologists and staff were satisfied with the program. The majority of workers: felt they were referred for counselling when they needed it; were helped to understand and deal with the pain they experienced; had enough counselling sessions; and were generally satisfied with the counselling they received. Also, more workers recommended the FRP to other injured workers than those who did not recommend the program, and while most indicated the program did not help them return to work, many returned to work at the end of the program and the majority were employed at the time of the survey. Workers who participated in Phase I only or both Phase I and II reported they were helped to a greater extent and experienced better outcomes than those who participated in Phase II only. Psychologists and staff reported that workers benefited from the counselling services.

4.2.2 Methodology

A stakeholder analysis was first conducted to identify groups who were impacted by, or directly involved in, the program. Through this process, workers who participated in the program, along with WCBNS staff and psychologists had the greatest involvement and therefore were considered the primary stakeholders in the comprehensive evaluation. A mixed-methodological approach was used for the post-program evaluation of the FRP, meaning that a number of different sources and types of information were used to evaluate the program. First, an analysis of existing administrative data (on the AS/400 system) was conducted to determine participation rates and use of FRP services. The WCBNS commissioned Corporate Research Associates (CRA), a public opinion and market research company, to conduct a telephone survey of injured workers who participated in the FRP.¹⁰ The FRP Evaluation Committee, an Ad Hoc internal committee which consisted of members from most Departments within the WCBNS, conducted (1) a mail survey of psychologists who offered FRP-

related counselling¹¹; and (2) a mail survey of WCBNS staff who were directly involved in the program.¹² Participation in all three surveys was voluntary, individuals could not be identified, and group responses were reported (Figure 2).

Figure 2. Methodology for the FRP Evaluation.



4.2.3 Response Rates

Survey response rates were highest for participants of the FRP and lowest for psychologists. CRA attempted to reach 160 workers who (1) were within 12 months of their date of injury at the time of FRP service delivery; (2) had completed at least one phase of the FRP; and (3) who received pain-related psychological counselling. There were 33 telephone numbers which were not in service/wrong, 19 where there was no answer after five attempts or were not available during the interview period, and only seven refusals, for a response rate of 80% ($N=101$, $101/127=80\%$). Twenty-four of the 41 questionnaires distributed to psychologists (approved by the WCBNS to offer FRP counselling services) were completed and returned, for a response rate of 59%. Forty-five of the 60 staff members

10 See Appendix E for the Summary Report.

11 See Appendix F.

12 See Appendix G.

who had direct involvement with the program (Adjudicators, Case Managers, Adjudication Advisors, Medical Advisors, Vocational Rehabilitation Counselors) responded to the survey, for a response rate of 75% (Table 2). The average response rate for all three surveys was 71%.

Table 2. FRP stakeholder evaluation method and response rates.

Stakeholder	Evaluation Method	Response Rate % (n)
FRP Program Participants (Injured Workers)	Phone Survey	80 (101)
Psychologists	Self-completion Mail Survey	59 (24)
WCB Staff	Self-completion Mail Survey	75 (45)

4.2.4 Training

Psychologists and staff were asked questions about the training they received. Most psychologists (86%) were satisfied with the information provided, fewer (58%) attended the formal FRP training session¹³ (Figure 3), most who did are satisfied with the session (92%), and many (71%) were interested in attending a follow-up/refreshers session (Figure 4).

Almost 3/4s of the staff respondents (71%) received the formal two-day FRP training session (Figure 3), 51% attended the Normal Recovery Times session and 62% attended the Introduction to Psychology session. A large majority of staff (82%) indicate they have enough training to make or approve FRP referrals yet 42% are interested in further FRP-related training (Figure 4). A small percentage (13%) of staff indicate they are not comfortable making referrals for psychological counselling. Clearly there are high satisfaction levels among psychologists and staff with the FRP-related training, however everyone did not receive the FRP training and many expressed interest in further educational opportunities related to chronic pain.

¹³ The formal FRP training was provided in 1996. Since that time, new staff have joined the WCBNS and did not receive the extensive formal FRP training.

Figure 3. Staff and psychologists who received FRP training.

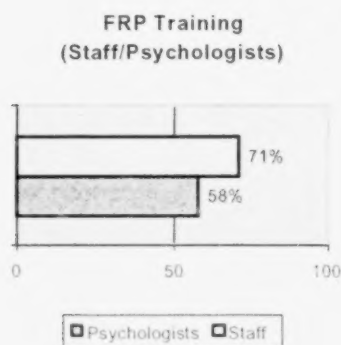
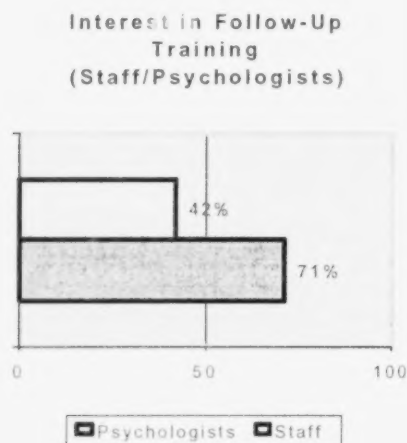


Figure 4. Staff and psychologists interested in follow-up training related to chronic pain.



4.2.5 FRP Referrals

Psychologists and staff were asked about FRP referrals. More than 3/4s (79%) of responding psychologists report receiving FRP referrals (Figure 5). The same percentage of psychologists reported that it was clear the referrals were for FRP counselling services. However, only 37% routinely

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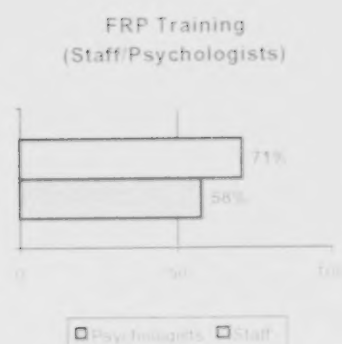
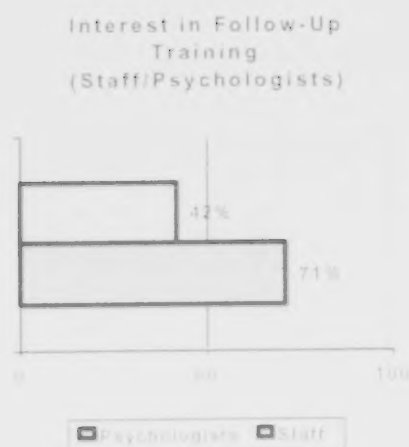


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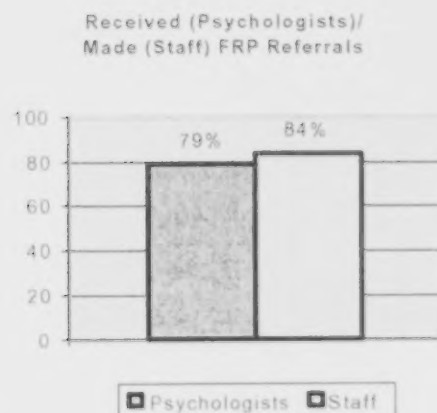
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received the referral form and less than half (47%) reported that sufficient information is provided by WCB about the needs/background of injured workers. Psychologists indicated that appropriate workers were referred for counselling however they were less satisfied with the timing of Phase I referrals and with the information provided to workers for Phase I counselling. The majority of psychologists reported a need to change the referral process by providing more information to the injured workers prior to the scheduled appointment about why they are being referred for psychological counselling, the benefits of the program, what to expect from counselling and to anticipate 2-3 weeks wait for the first appointment. Also, psychologists requested consistent information be provided about referred injured workers and their needs, as well as clear expectations from WCB about reporting requirements and service expectations.

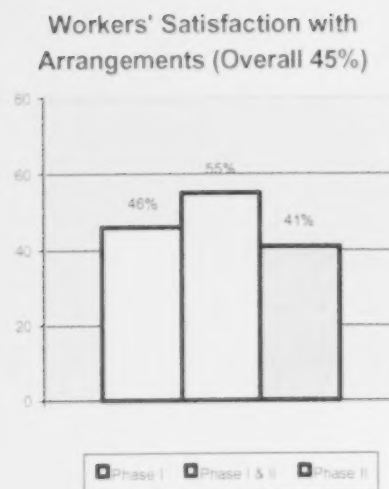
Most (84%) staff members surveyed made FRP referrals (Figure 5). Of those who referred, staff report it easier to identify workers for Phase II of the FRP than for Phase I. Fewer than half of those who refer (43%) always used the FRP referral form. Staff report inconsistent receipt of psychologists' reports and suggest there is a need for timely receipt of reports. Staff required assistance in identifying workers for, and making, Phase I referrals, and there was a need to consistently use the referral form.

Figure 5. Staff/psychologists who made/received FRP referrals.



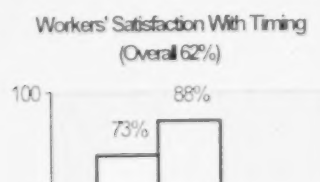
Overall, workers are moderately satisfied (overall 45% completely/ mostly) with the arrangements made by their Case Worker (Figure 6). Workers who participate in both phases are more satisfied (55%) with the arrangements made by their Case Worker than those in Phase I only (46%) or Phase II only (41%).

Figure 6. Workers' overall satisfaction with the arrangements made by their WCBNS Case Worker for FRP services.



Workers were more satisfied (overall 62% completely/mostly) with the timing of referrals for counselling (Figure 7). Workers who complete both phases were more likely to agree that their case worker referred them for counselling when they needed it: 88% compared to 73% for Phase I only and 41% for Phase II only.

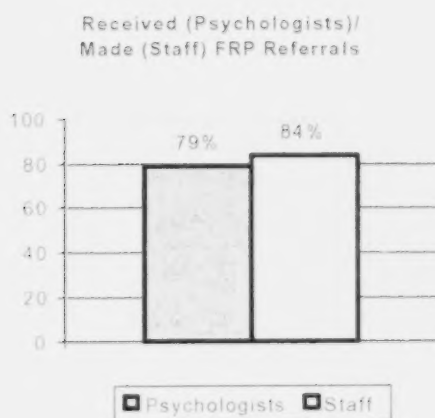
Figure 7. Workers' satisfaction with timing of referrals for FRP counselling.



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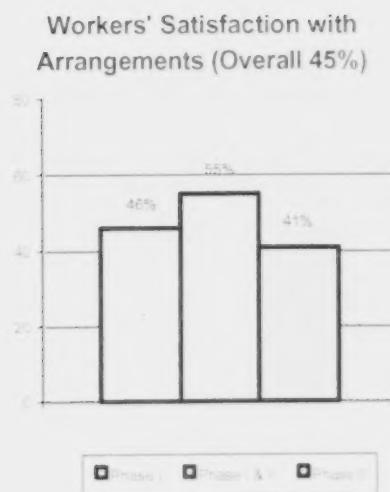
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Figure 5. Staff psychologists who made/received FRP referrals.



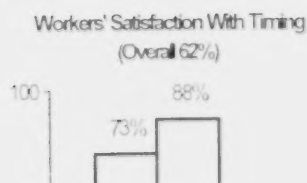
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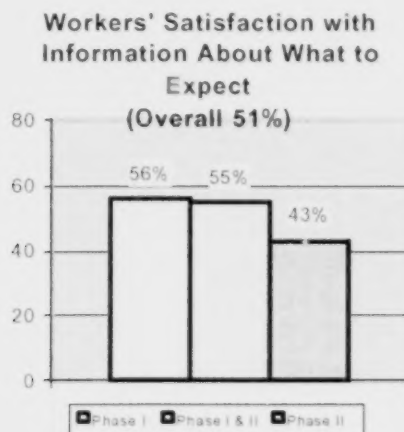
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Overall, a slim majority of workers agreed (51% completely/mostly) that they were provided with information about what to expect from counselling (Figure 8). Workers who participated in both phases were less likely to agree that their case worker provided them with information to help them understand what to expect from counselling (43%) than those in Phase I only (56%) or Phase II only (55%). Clearly, these results confirmed the need to improve the referral and reporting process and to improve communication between WCB staff, workers and psychologists.

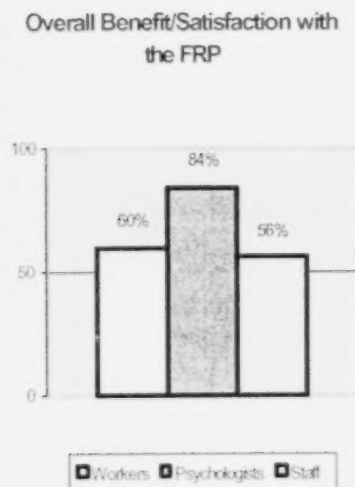
Figure 8. Workers' satisfaction with information about what to expect from FRP counselling.



4.2.6 FRP Services

Workers, psychologists and staff evaluated the FRP services. Overall, most psychologists (84%) were satisfied with the program and believed the counselling helped workers in Phase I (100%) and most believed FRP was beneficial for those injured workers who participated only in Phase II (79%). Further, the majority of workers (60%) believed it helped them with their pain and the majority of staff (56%) was satisfied with the FRP (Figure 9).

Figure 9. Overall stakeholder satisfaction with the FRP.

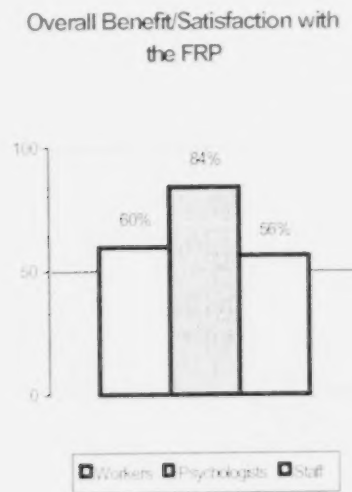


FRP participants were more likely to report that the program helped them with their pain if they participated in Phase I only (63%) than those participants who received Phase II only (56%) or those in both Phase I & II (55%, Figure 10).

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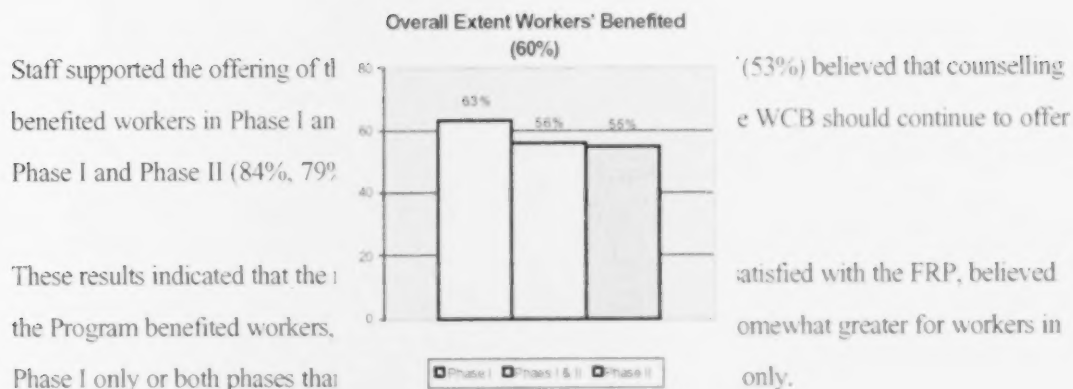
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Figure 10.

Workers' overall who benefited from the FRP.



Stakeholders were asked to evaluate the length of the FRP. Psychologists suggested that Phase II be extended to permit more weekly sessions (especially if the worker has not participated in Phase I of the FRP). Staff indicated that if workers participate in both Phase I and II, then four weeks for Phase II is adequate but if the worker participates in Phase II only then four weeks is not adequate.

Workers who participated in both phases received more counselling sessions (12.9 compared to 7.5 for Phase I only and 5.1 for Phase II only, Figure 11) and were more likely to agree that counselling helped them to understand their pain (77% compared to 58% for Phase I only and 48% for Phase II only, Figure 12); understand the roles that emotions, behaviors and attitudes played (77% compared to 70% for Phase II only and 65% for Phase I only, Figure 12); and helped them deal with their pain (55% for those in both phases or in Phase I only compared to 46% for Phase II only, Figure 13). Counselling had little apparent effect in reducing medication and increasing physical activity levels. Phase I only participants were more likely to agree that counselling helped them prepare to return to work (36%) compared to those in both phases (33%) or those in Phase II only (20%). Counselling helped workers understand pain and related issues more than it helped prepare them to return to work.

Figure 11. Number of counselling sessions received by FRP participants.

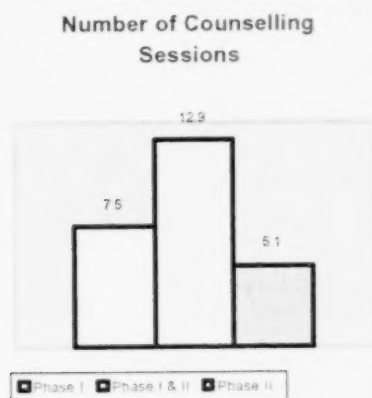


Figure 12. Workers who reported that FRP counselling helped them understand their pain and the roles emotions and behaviors play.

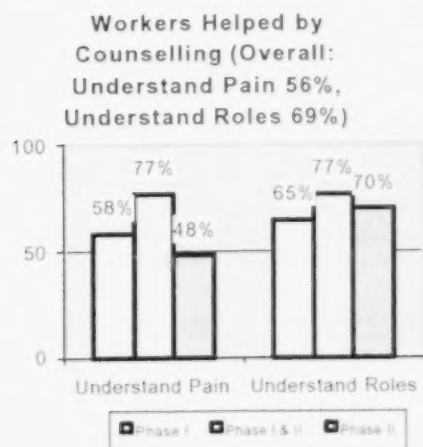
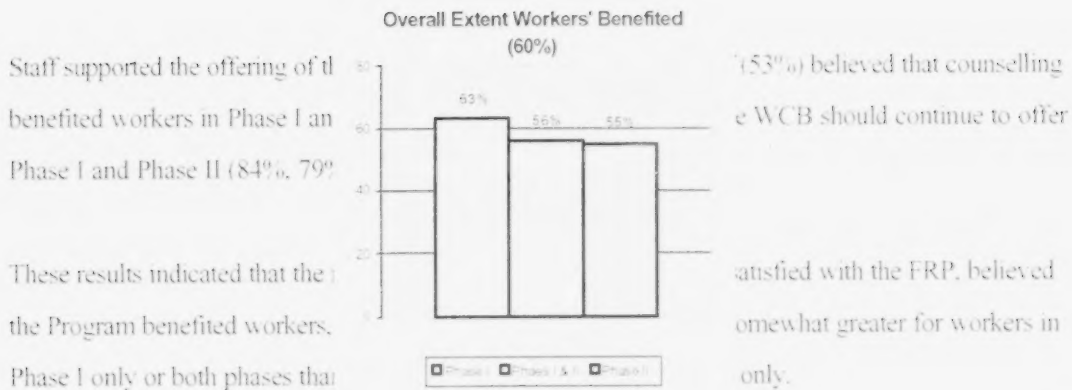


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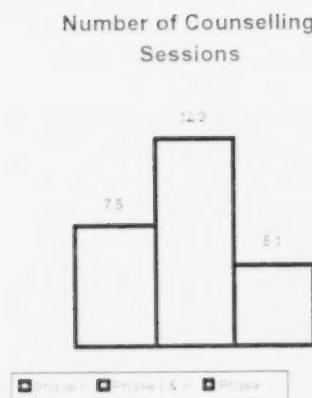


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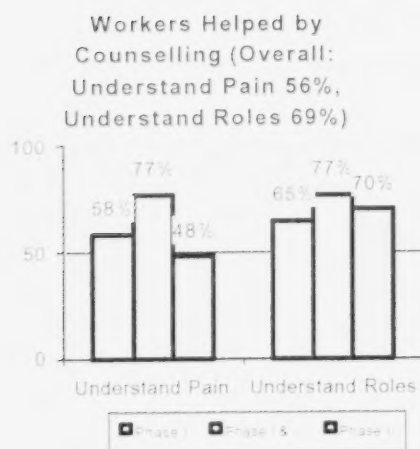
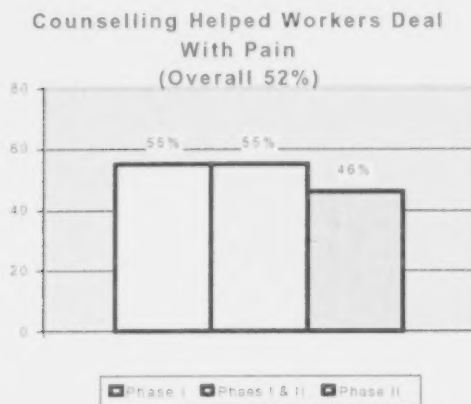


Figure 13. Workers who reported that counselling helped them deal with their pain.



Workers' suggestions for improvements to the FRP included a need to work with and listen to workers (for those in Phase I or Phase II only) while those in both phases requested that staff be more understanding and supportive.

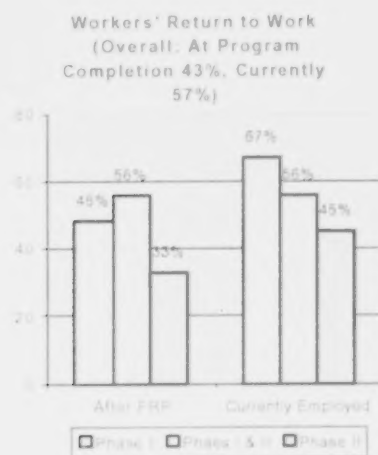
In addition to counselling, other pain-related services are offered to workers in the FRP. More workers received physiotherapy than chiropractic pain-target services (76 and 14 respectively), and more workers indicated that they were helped to a greater extent by physiotherapy than from chiropractic services.

Higher return to work rates for FRP participants at program completion (overall: 43%) and employment rates at the time of the survey (overall: 57% in Fall of 1999) were reported among those in Phase I only (48% and 67% respectively) or both phases (56% and 56%) compared to Phase II only (33% and 45% respectively, Figure 14). Of note, participants' overall return to work rates were higher than

reported for workers with chronic pain in other jurisdictions at the time of the evaluation in November of 1999 (BC: 31%; AB: 22%; ON: 8%; NB: 12%).¹⁴

¹⁴ Caution should be exercised in interpreting these numbers since other jurisdictions use differing definitions of chronic pain and provide various treatment options which are different from the FRP. See Appendix H for the Association of Workers' Compensation Boards of Canada's recent survey entitled Compensation for Chronic Pain 2000.

Figure 14. Workers' return to work rates after completion of the FRP and at the time of the survey ("currently employed").

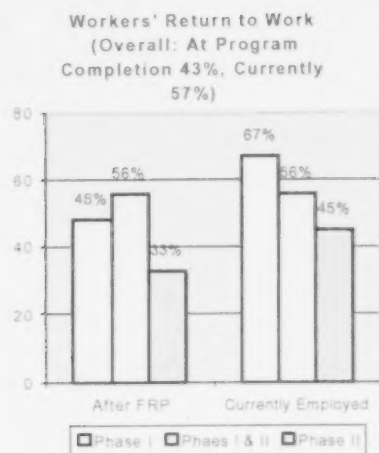


4.2.7 Evaluation Conclusions and Recommendations

There was support for the FRP among the majority of workers, psychologists and staff. Participation in the FRP helped prevent chronic pain. As well, the FRP assisted workers who experienced chronic pain to manage their pain. The majority of participants benefited from the program. As well, workers experienced higher return to work rates than have been reported in other jurisdictions. However, this was the first evaluation of a new program and it identified administrative changes that needed to be implemented so that the program increases its potential to benefit injured workers.

It was therefore recommended that the WCBNS continue to offer the FRP. Staff and psychologists require follow-up FRP-related training to assist with the identification of workers for timely referrals for Phase I services. Further, staff should be encouraged to offer Phase I services prior to Phase II and Phase II alone should rarely be approved. Staff requires training in communication so they are more attentive to workers needs and better communication tools, such as form letters, need to be developed. Also, wider distribution of FRP information brochures to workers, service providers and others is recommended. There is a need to review the FRP-related procedures to ensure they are consistent with the current restructuring of positions in Client Services. Further, there is need for a generic referral

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form and for consistent use of the form when making arrangements with service providers. As well, the development of communication material outlining the program, its intended benefits and the types of services that could be provided would be beneficial for injured workers. Consideration should be given to revising and simplifying the internal consultation form. Clarification of the criteria on the form will assist staff with the identification of workers who would benefit from the FRP. Psychologists, like all service providers, must clearly understand and comply with WCBNS's reporting requirements. Timely and consistent receipt of service providers' reports will further enhance communication and the co-ordination of pain-targeted services. Finally, the FRP requires close monitoring to ensure consistent quality data collection and continuous quality improvement. While the evaluation results demonstrated that the FRP has been effective in serving the majority of its clients, the WCBNS recognizes that attention to quality is necessary to ensure future participants' needs are met through the program.

5.0 IMPLEMENTATION OF FRP EVALUATION RECOMMENDATIONS

The FRP Evaluation Report (including recommendations) was submitted to the Board of Directors in November 1999. Following a discussion at their January 2000 meeting, the Board of Directors approved the continuation of the FRP with the understanding that the administrative changes highlighted in the FRP evaluation would take place. Staff were in the process of implementing these changes when on January 31, 2000 the Workers' Compensation Appeals Tribunal (WCAT) rendered three decisions regarding some key legislative provisions and *Regulations* for chronic pain – one of which directly impacted the FRP policies and program. After these decisions were released, the WCBNS suspended the FRP pending the outcome of an appeal of the two WCAT decisions to the Nova Scotia Court of Appeal (NSCA). On November 8, 2000 the NSCA released a single decision which overturned the two appealed WCAT decisions and led to the reinstatement of the FRP. This decision enabled the staff of the WCBNS to continue with the implementation of FRP evaluation recommendations.

A number of changes have taken place to improve the administration of the FRP. The FRP process and procedures have been reviewed and simplified. For example: the need for formal approval by a medical advisor before referring a client to FRP Phase II has been eliminated; the referral form was

redesigned to capture the relevant information required by psychologists to assist with appropriate diagnosis and treatment; reporting requirements of the treating clinicians have been more clearly outlined and standardized to improve consistency and communication between FRP- service providers and staff; letter and decision documentation templates have been developed to standardize and improve communication between the WCB, injured workers, family physicians and treating psychologists.

The process by which psychological intervention, anticipated by the FRP, offered to clients for FRP Phase I has been revised. As of August 1, 2001 the WCBNS adopted the Pain Disability Prevention (PDP) Program as the treatment protocol for clients referred for FRP Phase I psychological counselling. The purpose of this change was to provide a more standardized psychological counselling intervention and to provide a mechanism which, based on the current research evidence, incorporated the use of goal setting, increased activity and function and weekly objective monitoring of progress. The PDP Program aims to reduce disability related to pain and to increase a client's physical activity during the treatment and recovery phase of the injury.

The referral process to FRP Phase II and the treatment protocol is largely unchanged although staff have been re-educated to the need for early referral to FRP Phase I before offering Phase II in order to reduce the population of injured workers who only receive FRP Phase II.

All FRP-related material is now available to staff electronically for immediate access through the WCBNS's internal Internet (the Intranet). This change is expected to help staff implement the simplified and streamlined FRP referral and reporting procedures.

In addition to the supports available to staff through regular case management meetings and support provided on an "as needed" basis by subject matter experts, time is scheduled weekly for staff to seek advice on claims where chronic pain or a timely return to work may be a concern.

Follow-up training sessions for both staff and psychologists have been provided as recommended in the FRP evaluation. In May 2001, staff attended a session on disability case management which included

information about return to work case planning, re-employment and how to identify cases where early intervention to prevent the development of chronic pain is required. Staff were provided general information about pain and more specifically information about chronic pain and how to assist workers who may be at risk of developing chronic pain. All Case Workers, Medical Advisors and Internal Appeals staff were invited to attend the sessions.

In June and July of 2001 there was a subsequent follow-up training session. This session highlighted the streamlined administrative process for the FRP. As well, staff were provided information to: (1) identify injured workers who might benefit from Phase I of the FRP; (2) ensure, to the extent possible, that workers are offered Phase I of the FRP since prevention of chronic pain is known to be more effective than treating chronic pain once it has developed (and thereby reducing the number of workers who receive only Phase II of the FRP); (3) more efficiently provide the FRP services; and to (4) reinforce the biopsychosocial model as the approach to managing clients at risk of or who have developed chronic pain.

A final training session was offered to staff during the summer of 2001. This session, as recommended in the FRP evaluation, was designed specifically to assist staff communicate with injured workers who might benefit from psychological counselling within the FRP.

In June of 2001, all registered psychologists in Nova Scotia were invited to participate in the follow-up FRP training. Over eighty psychologists attended a one-day workshop which provided an overview of the FRP, the PDP component for Phase I, the protocol for Phase II of the FRP, and the reporting requirements and procedures.

Other communication tools, as recommended in the FRP evaluation, have been developed. A new brochure was developed by the WCBNS Communication Department, which outlines the benefits of the FRP and services provided. The brochure targets injured workers, their treating physicians and other health service providers. As well, new form letters have been designed to provide information

about the program and its benefits to injured workers at the time they are referred for FRP-related services.

A number of activities have taken place to increase physicians' understanding of the prevention, treatment and management of injured workers with chronic pain. Throughout 2000, outreach sessions were initiated by the WCBNS Communication and Medical Departments to provide physicians with general information about the WCBNS, its policies and to provide opportunities to discuss specific health issues such as chronic pain. Dalhousie Medical School students also receive information about chronic pain through presentations to students in their first year and by participating in second year and/or fourth year rotations at the WCBNS. Currently the Medical Director of the WCBNS is exploring on-line medical education opportunities with Dalhousie University's Department of Continuing Medical Education. In addition, the Director of the WCBNS Medical Department regularly attends clinical meetings held at the QEII Pain Clinic where the current chronic pain research is presented and discussed. Most recently, in the Spring of 2001, the Director of the WCBNS Medical was invited to present at a seminar on pain, organized by the QEII Pain Clinic.

The FRP data collection screens (i.e. the AS/400 screens) were revised with the following objectives in mind: (1) to minimize the work required by staff to capture the relevant data for program evaluation; (2) to enable staff to better monitor program costs, and (3) improve data quality. These changes were completed in July 2001. It is intended that a monthly report will be produced for Managers and staff to enable them to monitor return to work success rates following FRP intervention.

As is the case with all major policy areas, staff continue to monitor the literature to ensure that the FRP policies and provisions continue to be consistent with the current evidence-based research on chronic pain. Staff and representative members of the Board of Directors attended an international conference on chronic pain, held in New York in November 29 to December 2, 2000 (*Back Pain and Disability – Unraveling the Puzzle*). Research findings presented at that conference confirmed the appropriateness of the WCBNS's approach to the prevention and management of chronic pain. In fact,

the WCBNS was identified by a conference presenter and researcher as a leader in the field for its chronic pain policies and legislative provisions.

6.0 RECENT LEGAL CHALLENGES TO THE CHRONIC PAIN PROVISIONS

The legislative provisions dealing with chronic pain have undergone a series of challenges since they were first introduced with the new *Act* (Bill 122, February 1, 1996) and revised in a more recent legislative amendment introduced in April 1999 (Bill 90). The Nova Scotia Court of Appeal decision *Doward v. Workers' Compensation Appeals Tribunal and the Workers' Compensation Board of Nova Scotia* ("*Doward*"), issued in April 1997, was one of the first decisions interpreting the legislative provision of benefits for chronic pain. This was a case of myofascial pain syndrome which developed following injuries in a car accident. The various stages of this appeal effectively ruled on several points. The *FRP Regulations* were intended to be fully retroactive but *Doward* limited their retroactivity to February 1, 1996 and made important rulings about workers injured during the "window" period on or after March 23, 1990 and before February 1, 1996. The *Doward* decision raised the question as to whether workers injured in the "window" period were entitled to benefits for chronic pain. More generally, *Doward* addressed the notion that while eligibility for workers compensation depended on the demonstration of impairment (as required by the legislation), wage replacement was directed to incapacity for work and should therefore be based on actual loss of earnings as a result of the work-related injury.

The result of the *Doward* and subsequent Court decisions was a determination that chronic pain might be compensable for injuries during the "window" period of March 23, 1990 to January 31, 1996. In 1998, in response to the Court's interpretation of the *Act* and *FRP Regulations*, the Board of Directors approved a series of Policies outlining eligibility for permanent benefits for chronic pain during the window period. The policies affected workers:

- (i) who were injured between March 23, 1990 and January 31, 1996;
- (ii) developed chronic pain subsequent to the injury; and

(iii) as of April 18, 1997 had an open claim with the WCB or an outstanding appeal with the WCB, WCAT or the Court of Appeal; and

(iv) had not yet received a final decision on their claim.

Included in the Policies was an assessment tool called Marked Life Disruption Assessment (MLDA), utilized to assess the impact that chronic pain may have on an individual's life. This measurement tool was designed to be objective, consistent, reproducible and fair. The MLDA included a series of scientifically validated psychological tests and a structured interview with a registered psychologist specifically trained in this area. As a result of this process, a worker was categorized as having mild, moderate, severe or extreme marked life disruption.

The WCBNS used the findings of the MLDA to establish the permanent medical impairment (PMI) of the injured worker where one did not already exist for the compensable injury. For those affected injured workers who already had a PMI as a result of their work related accident, the WCB utilized the existing PMI rating rather than the one established through the MLDA process. Existing PMI ratings were not "topped up" by addition of the PMI determined through the MDLA process. The MLDA-determined PMI was only to be used where there was not an existing PMI for the injury being compensated. The WCB then determined if the worker had experienced a compensable earnings loss as a result of his or her impairment. If a worker had not experienced an earnings loss as a result of the chronic pain, the worker was still entitled to a permanent impairment benefit (PIB). The WCB set up a Special Services Unit (SSU) to work with injured workers affected by the new policies.

Other concurrent activities were taking place during the establishment of the SSU. There were subsequent Court of Appeal decisions along with the Auditor General's *Audit of the Nova Scotia Workers' Compensation System* and the *Report of the Nova Scotia Select Committee on the Workers' Compensation Act* (November 1998). These activities culminated in legislative change. In April 1999, the Nova Scotia Legislature passed *Bill No. 90 An Act to Amend Chapter 10 of the Acts 1994-95, the Workers' Compensation Act*. *Bill 90* included several provisions, outlined in Sections 10A to 10I, relating to chronic pain.

Section 10A of *Bill 90* defined chronic pain – the same definition as contained in the *FRP Regulations*. Section 10B clarified that workplace injuries which occurred in the “window” period were deemed never to have included chronic pain and there was no pre-February 1, 1996 vested right to compensation for chronic pain. Section 10E provided benefits to workers who were injured in the “window” period (on or after March 23, 1990 and before February 1, 1996) who developed chronic pain subsequent to a work injury and who were receiving temporary benefits or were in the appeals system as of November 25, 1998 (the date *Bill 90* was introduced in the Legislature). Section 10E benefits provided for a permanent impairment award of 25% multiplied by 50% and an extended earnings replacement benefit (if payable pursuant to sections 37 to 49) multiplied by 50%. Section 10G enabled the WCB to pay medical aid benefits to workers who met the criteria of Section 10E. In summary, the effects of the chronic pain provisions of *Bill 90* were: (a) to preclude the payment of compensation to workers with chronic pain who were injured prior to March 23, 1990; (b) to provide apportioned permanent benefits to certain workers injured on or after March 23, 1990 and before February 1, 1996; and (c) to confirm that the only compensation payable to workers with chronic pain injured on or after February 1, 1996 was that provided for in the *FRP Regulations*.

The WCB stopped referring workers for MLDA after April 1999 because the level of permanent medical impairment (PMI) under Section 10E was directed by the legislation to be 12.5% for all eligible workers. This 12.5% PMI for chronic pain was in addition to any non-chronic pain PMI a worker might already possess. The WCB continued to determine whether a worker had a compensable loss of earnings as a result of the impairment. If a worker did not experience a loss of earnings as a result of the impairment, the worker was entitled to a Permanent Impairment Benefit (PIB) only. If the worker did have an earnings loss, the amount of any Extended Earnings Replacement Benefit (EERB) payable was determined in accordance with the Act and 50% of the amount determined was payable to the worker.

On January 31, 2000 the Nova Scotia Workers' Compensation Appeals Tribunal (WCAT) released three decisions on appeals by injured workers with chronic pain. In Decision No. 96-025-AD, the

WCAT ruled that section 10E was discriminatory but found it was saved by section 1 of the *Charter of Rights and Freedoms* as it allowed for a possible permanent benefit award. In Decision No. 99-641-AD, the WCAT determined that sub-sections 10B(b) and 10B(c) were unconstitutional, in that they precluded the payment of any benefits for chronic pain for workers injured before March 23, 1990 (the "Laseur Decision"). In Decision No. 98-077-AD, the WCAT decided that the *FRP Regulations* were unconstitutional (the "Martin Decision") as they were found by the Tribunal to discriminate against workers and not allow them a permanent impairment benefit offending Section 15 of the *Charter of Rights and Freedoms* ('the Charter'). In the *Martin* and *Laseur* decisions, the WCAT found that the identified discrimination was not a reasonable limit in a free and democratic society and therefore not "saved" by Section 1 of the *Charter*. Between January and November 2000, the *FRP Regulations* were suspended and workers with chronic pain continued to receive their workers' compensation benefits and pain targeted services if appropriate.

The WCBNS appealed Decision No. 99-641-AD (the "Laseur Decision") and Decision No. 98-077-AD (the "Martin Decision") to the Nova Scotia Court of Appeal. The WCB continued to pay benefits pursuant to section 10E and provide some pain targeted services to help workers in the interim.

In a single decision rendered on November 8, 2000 the Nova Scotia Court of Appeal (NSCA) overturned both of the WCAT decisions in *Martin* and *Laseur* and ruled that the *FRP Regulations* and relevant chronic pain legislative provisions were indeed constitutional. Moreover, the NSCA found that the *FRP Regulations* were appropriate from both a legal and medical perspective [*Martin v. Workers' Compensation Board (NS) et al.* (2000) NSCA 126].

In January 2001 the Workers' Advisor Program (WAP) applied for leave to appeal the NSCA decision in *Martin* and *Laseur* to the Supreme Court of Canada (SCC). In June of 2001 the SCC granted leave to appeal on both *Martin* and *Laseur*. It is currently anticipated that the SCC will not hear the appeals until the early Summer or the Fall of 2002 and a decision will likely not be issued before 2003. In the interim the WCBNS will continue to apply the chronic pain sections of the *Act* and

the FRP Regulations as confirmed by the NSCA as an appeal of the NSCA decision to the SCC does not act as a stay. The NSCA has approximately 150 chronic pain related appeals before it at present. However, the NSCA has recently decided to postpone any decisions regarding these appeals until June 23, 2003 and it is anticipated that the SCC *Laseur* and *Martin* decisions will be issued by this time.

Appendix A. POLICY NUMBER: 2. 4. 1R

Effective Date: January 1, 2000

Date Issued: December 16, 1999

Date Approved by Board of Directors: December 3, 1999

Topic Phase I - Pain Targeted Services

Section: Health Care

Subsection: Functional Restoration Program

General: Supporting Philosophy

Early Assistance requires that the appropriate services be offered at the appropriate time, and indicates that a pro-active rehabilitation approach is the most effective. This philosophy underlines the necessity to become pro-active in the prevention and management of Chronic pain. The introduction of pain targeted services during Case Management should be beneficial to clients who are at risk of developing chronic pain by addressing the pain barriers in an effective and timely fashion as part of the Case Plan.

Policy Statement

1. If, during the normal course of Case Management, the Case Worker identifies pain as becoming prominent as a limiting factor in the return-to-work process, the Case Worker may recommend that pain-targeted services be offered to the client.
2. The program of pain-targeted services is offered as a complement to the services already in progress under the Case Plan, and does not preclude the client from receiving any authorized health care services which would normally be available under case management. The addition of pain-targeted services will not change the completion date of the Case Plan. Participation in the FRP is voluntary and will have no impact in any case management or benefit entitlement decisions.
3. Phase I pain-targeted services may consist of, psychological assessment and counseling specific to pain behavior, pain-targeted programs offered by rehabilitation professionals, the provision of educational materials/ pain management workbook, or any other pain targeted-services that may be considered appropriate (e.g. drug counseling). The worker will participate in the decision with regard to what service or combination of service is appropriate.
4. The Phase I pain-targeted services shall be capped at a maximum program costs of \$2000.00 per client.
5. Within the program costs, the number of psychological counseling sessions shall be capped at a maximum of 12 visits.

Application

This Policy applies to all decisions, orders, or rulings made on or after January 1, 2000.

References

Regulation 96-207, Functional Restoration (Multi-faceted Pain Services) Program Regulations.

Appendix B. POLICY NUMBER: 2. 4. 2

Effective Date: February 1, 1996

Date Issued: April 30, 1996

Date Approved by Board of Directors: April 12, 1996

Topic: Phase II - Multi-Faceted Pain Services: Criteria

Section: Health Care

Subsection: Functional Restoration Program

General: Objective of Phase II

The objective of the functional restoration program is to manage the pain and pain-related symptoms as the limiting factors with regards to return-to-work. The program cannot guarantee a return-to-work status or elimination of the pain.

Policy Statement

1. If, upon completion of the Case Plan, the Case Worker determines that the client is experiencing or continues to experience pain as a barrier to return-to-work, the client may be considered under the eligibility criteria for Phase II of the Functional Restoration Program.

2. No client may be designated as a participant in the program unless they meet all of the following criteria.

a. The client suffered a compensable injury which is followed by pain which persists beyond the normal healing time for the type of compensable injury or that is disproportionate to the type of compensable injury;

b. the client has not returned to full pre-injury earnings (*Note: they may have returned part-time, or to a modified version of their pre-injury employment*);

c. the client continues to report pain and pain-related symptoms, and identify the pain and related symptoms as the reason for their failure to return full-time to their pre-injury earnings;

d. there is no evidence of major non-compensable problems or malingering; and

i) based on the existing medical evidence, there is no persuasive evidence of an organic cause for their pain; or

ii) based on the permanent medical impairment rating given by the Workers' Compensation Board, there is evidence of an organic cause for their pain, but

their reports of pain and subsequent effect of the pain on their return to work is disproportionate with the cause (*pain magnification*);

e. the client is at least twelve weeks post-injury;

f. the Case Plan has been fully implemented, including appropriate active health care services and pain-targeted services;

g. in the opinion of the Case Worker, the client is likely to be capable of returning to work following completion of the program;

h. in the opinion of the Case Worker, the major limit to the client's return to full earnings is the pain and related symptoms;

i. in the opinion of the Case Worker, the client is motivated to participate in the further program of pain management services; and

j. the client is in receipt of temporary earnings replacements benefits at the time of consideration for Phase II of the FRP.

3. In reference to criteria 2(e) above, if the eligibility period for benefits is less than 12 weeks (e.g. there is no longer sufficient evidence of a compensable injury to continue the claim for benefits) and the client fits the other eligibility criteria, the claim will be referred to the Case Review Committee for a decision on a waiver of the 12 week requirement.

4. In reference to criteria 2(f) above, if it is determined that the Case Plan or the health care services have not been appropriate or other options are available, the case plan may be modified and the client may continue to receive temporary benefits and will receive the appropriate Case Management services. If the client is within the criteria of the program following the full execution of the revised case plan, the client may again be considered for the Functional Restoration Program - Phase II.

5. In reference to criteria 2 (i) above, the Case Worker will make a decision about the client's motivation to accept the objectives of the program and participate fully in the services offered in part by assessing:

a. the client's participation in the case management process; and

b. the client's success or documented potential for success in the pain-targeted services.

Application

This Policy applies to all decisions, orders, or rulings made pursuant to the Act on or after February 1, 1996.

References

Regulation 96-207, Functional Restoration (Multi-faceted Pain Services) Program Regulations.

Appendix C. POLICY NUMBER 2.4.3

Effective Date: February 1, 1996

Date Issued: April 30, 1996

Date Approved by Board of Directors: April 12, 1996

Topic: Program Costs of Phase II

Section: Health Care

Subsection: Functional Restoration Program

Policy Statement

1. The Phase II program costs shall be capped at a maximum of \$8000.00 per client. The program costs may include costs for client travel and/or lodging, where appropriate.
2. Services offered and completed during Phase I will not be duplicated in Phase II.
3. Upon completion of the Phase II services, the client will not be eligible for additional benefits or pain-specific services.
4. A client shall only be eligible for one Phase II program for each compensable injury.

Application

This Policy applies to all decisions, orders, or rulings made pursuant to the Act on or after February 1, 1996.

References

Regulation 96-207, Functional Restoration (Multi-faceted Pain Services) Program Regulations.

Appendix D. POLICY NUMBER 2.4.4

Effective Date: February 1, 1996

Date Issued: April 30, 1996

Date Approved by Board of Directors: April 12, 1996

Topic: Consideration of Workers who are Beyond 12 Months of the Date of their Injury

Section: Health Care

Subsection: Functional Restoration Program

Policy Statement:

1. A worker who is beyond 12 months of the date of their injury may be considered for Phase II services where the worker:

- a. has been assigned a permanent medical impairment rating by the Board before February 1, 1996;
- b. has not yet received a permanent award from the Board; and
- c. has an earnings loss as a result of the compensable injury.

2. A worker who is beyond 12 months of the date of their injury may be considered for Phase II services where the Appeal Board has made a finding before February 1, 1996 that the worker has a permanent impairment in connection with chronic pain and the worker's permanent impairment rating will be fixed in accordance with Policy 3.9.6 [*Implementation of Appeal Board Decisions on Permanent Compensation in the Absence of Measurable Impairment*].

3. A worker who meets the above definition shall be considered under the criteria in Policy 2.4.2 with the exception of criteria 2(f) [full implementation of the Case Plan] and 2(j) [client currently in receipt of TERB].

4. If it is determined that additional case management services are warranted, Phase I services may be offered to workers identified in Section (1) or (2).

Application

This Policy applies to all decisions, orders, or rulings made pursuant to the Act on or after February 1, 1996.

References

Regulation 96-207, Functional Restoration (Multi-faceted Pain Services) Program Regulations.

**APPENDIX E: Functional Restoration Program
1999 Evaluation Survey Summary Report**

Functional Restoration Program

1999 Evaluation Survey

Summary Report

Prepared for the:

Workers' Compensation Board of Nova Scotia

November 1999

C O R P O R A T E R E S E A R C H
A S S O C I A T E S I N C .



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Introduction

The Workers' Compensation Board (WCB) of Nova Scotia was established in 1917 to provide financial benefits and rehabilitation services to injured workers in the province. In the past several years, the workers' compensation system has been significantly overhauled to improve the efficiency and effectiveness with which these services are provided. As part of these changes, the WCB established corporate performance measures to provide organizational focus and long-term measurable targets consistent with the organization's vision, mission and values. Corporate performance is now being evaluated using internal and external measures, including annual surveys with the organization's most important stakeholders, consisting of employers, WCB employees and injured workers.

One of the services that the WCB currently offers to injured workers is the Functional Restoration Program (FRP), which is designed to assist workers in preventing and managing chronic pain. The objective of Phase I of the FRP is the prevention of chronic pain while the objective of Phase II is to manage the pain and pain-related symptoms as the factors limiting a return to the workplace. Phase I of the program is offered in conjunction with regular case management activities to eligible workers identified as potentially benefiting from the types of services while pain-targeted services and 4 weeks of financial assistance in Phase II are offered after regular case management is completed.

The FRP is a three-year pilot program that is to be reviewed on a yearly basis, followed by a comprehensive program evaluation at the end of this three-year period. As part of the comprehensive evaluation, the WCB commissioned a survey of FRP clients to evaluate their satisfaction with the program services, as well as the degree to which the program assisted them in dealing with their pain. This survey was conducted by Corporate Research Associates Inc., on behalf of the WCB.

The study is based on telephone interviews with 101 FRP participants, conducted between September 15 and 28, 1999. Because this sample represents 80 percent of all program participants, it approaches a census and the results can therefore be considered a true reflection of this full population (i.e. with virtually no sampling error). A more complete description of the methodology is provided at the end of the report.

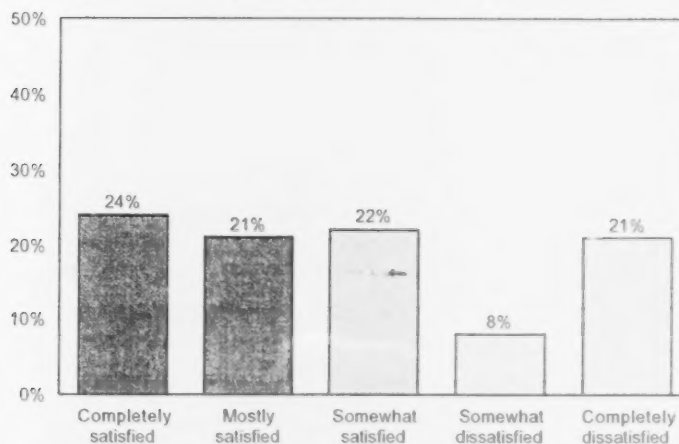
The following summary presents key highlights from survey, drawn from a more detailed report that was prepared for the WCB. Unless otherwise noted, all results are expressed as a percentage.

Caseworker Assistance

Despite the fact that less than half of clients are satisfied with the arrangements for counselling sessions made by their case worker, most believe they were referred for counselling when they needed it. No more than half felt they were provided with enough information prior to beginning the counselling.

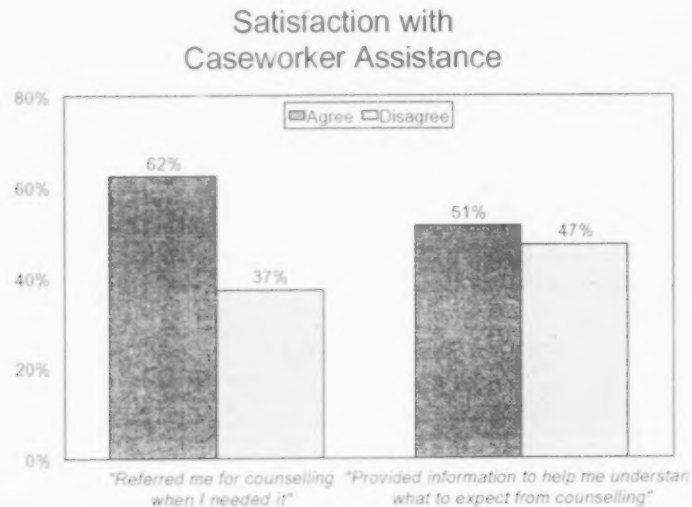
While it is clear that the WCB has some discontented clients, a large percentage is, in fact, clearly positive about their experience. Just under half of the clients surveyed say they are completely or mostly satisfied (which constitutes those who are clearly positive and is defined as the “top box” score) with the overall arrangements made by their case worker in terms of assisting them in getting the counselling sessions needed for their pain, while half are divided between those who are somewhat satisfied (a response that reflects varying levels of satisfaction or dissatisfaction) and those who are somewhat or completely dissatisfied. Only a handful of clients do not have a definite opinion on the matter.

Overall Satisfaction with
Careworker Assistance



Given the fact that the Functional Restoration Program was established to help workers prevent and manage chronic pain, a crucial component of the program is the referral of the client for pain-related counselling, and the program appears to have been effective in this way for most clients. Just over six in ten either completely or mostly agree that they were referred for such counselling in a timely manner, while less than four in ten of the clients surveyed either mostly or completely disagree with this view.

A key role of the case worker is to provide their clients with information to help them understand what to expect from the counselling sessions they are to embark upon. WCB clients are divided on whether or not they felt adequately prepared by their case worker for the counselling sessions. Half of those clients surveyed either completely or mostly agree that their case worker provided them with the information they needed to help them understand what to expect from the counselling they were to receive, while almost as many either mostly or completely disagree with this statement.

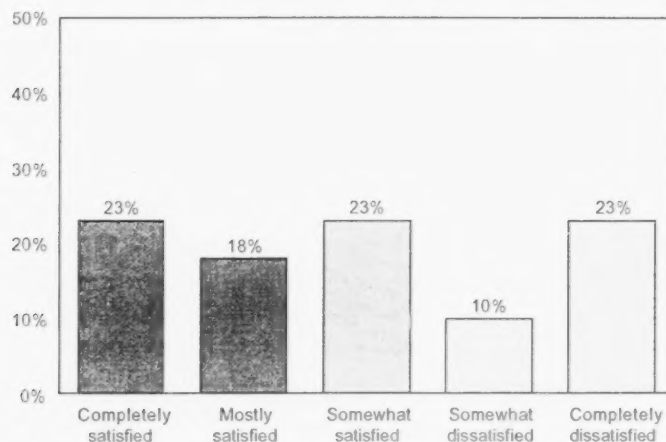


Counselling Sessions

While less than half are satisfied with the pain-related counselling sessions they received for their pain, nearly half would recommend this type of counselling.

WCB clients have mixed opinions concerning their level of satisfaction with the counselling sessions they received for their pain. Four in ten of clients say they are completely or mostly satisfied with the counselling sessions they received, while the remainder is divided between those who are somewhat satisfied and those who are somewhat or completely dissatisfied.

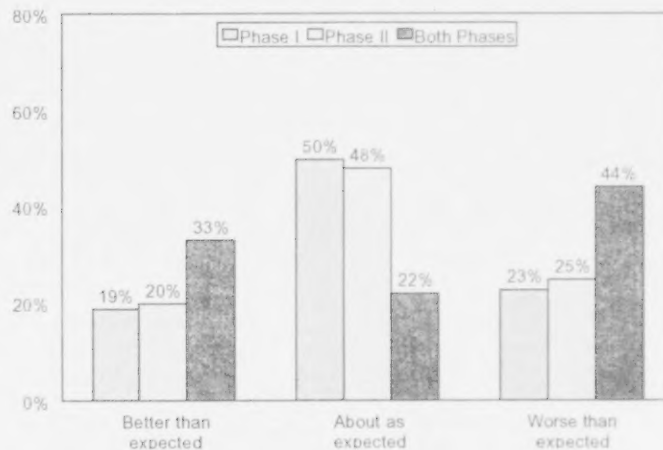
Overall Satisfaction with
Counselling Sessions



The survey also probed for reasons why clients were either satisfied or dissatisfied with the counselling sessions they received for their pain. Those who were at least somewhat satisfied were most likely to say this is because the qualified doctors were very helpful (22%), while others mentioned the fact that they were still in pain (14%) (most likely those who were somewhat satisfied, a response that can reflect a level of dissatisfaction), they received good information (13%), and they learned to deal with their pain (11%). Those dissatisfied with the counselling sessions they received for their pain (N=33) were most apt to say this is because they were still in pain (64%), felt the tapes they were given were not helpful (12%), believed it was not practical in the workforce (6%), and found the counsellor was not professional (6%).

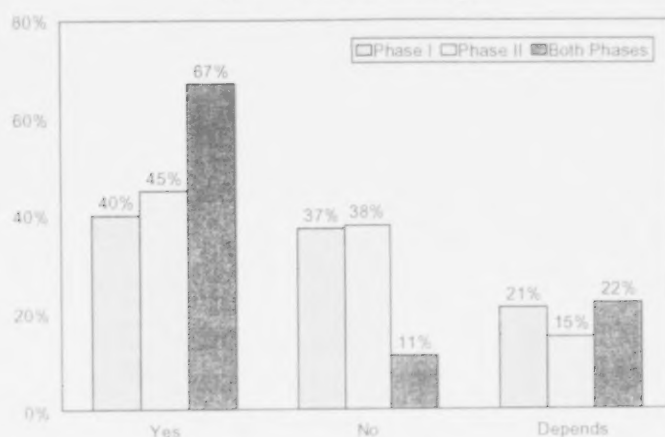
In addition to asking about overall satisfaction, clients were also asked about the extent to which their expectations concerning the counselling sessions were met. Overall, the majority (68%) of clients say the counselling sessions they received for their pain met or exceeded their expectations. Specifically, nearly seven in ten of the clients surveyed say their experience with the counselling sessions has been either as they expected or better than expected, while approximately one-quarter of clients said their experience was worse than expected.

Experience with Counselling Sessions
Compared with Expectations



Consistent with the relatively low level of satisfaction with the counselling sessions they received for their pain, WCB clients are split on whether or not they would recommend this type of counselling to another injured worker experiencing pain. More workers (45%) say they would recommend this type of counselling to another injured worker, while just over three in ten (35%) would not recommend such counselling. The remainder (21%) are unsure whether or not they would recommend this type of pain-related counselling to another injured worker experiencing pain.

Would you Recommend This Type of Counselling?

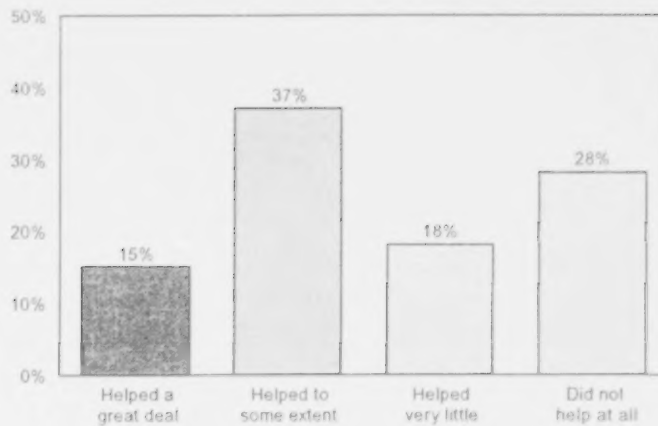


An area that may influence FRP clients' overall satisfaction with the counselling sessions is whether or not they feel they received an adequate level of counselling to assist them in dealing with the pain they are experiencing. Four in ten did not feel they received enough counselling to help them with their pain, although there is evidence of a positive relationship between the number of sessions attended and the impression of the level of help received. As the number of sessions attended rises to ten, FRP clients are more optimistic concerning the extent to which the sessions helped them. However, this positive rating declines slightly after ten sessions.

Half of FRP clients feel the counselling sessions helped them with their pain, but the sessions were more successful in increasing clients' understanding of their pain than in leading to positive outcomes.

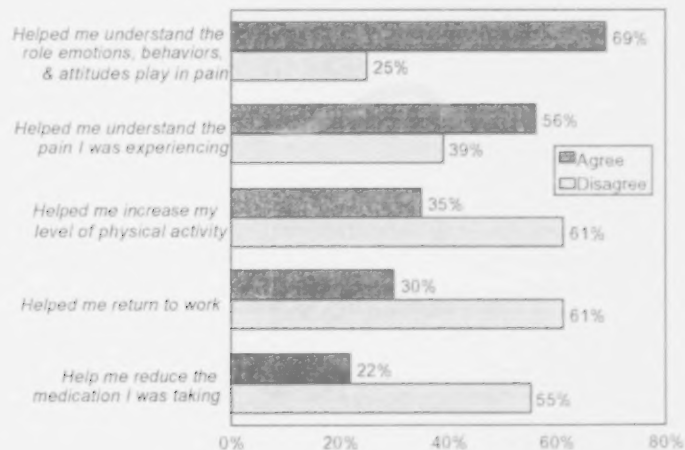
FRP clients have mixed opinions on the extent to which the pain-related counselling sessions helped them deal with the pain they were experiencing. Slightly more than half say the sessions either helped a great deal or helped to some extent, while just under half say the sessions helped very little or did not help at all with the pain they were experiencing.

To What Extent did Counselling Help with Your Pain?



FRP clients were also asked to evaluate the impact of the counselling sessions based on a variety of criteria. Most clients are satisfied with the extent to which the counselling sessions have helped them better understand the nature of their pain and the roles that emotions, behaviours and attitudes play in pain. However, clients do not believe these sessions have facilitated increased physical activity, a return to work, or a reduction in their medication usage.

Impact of Counselling Sessions

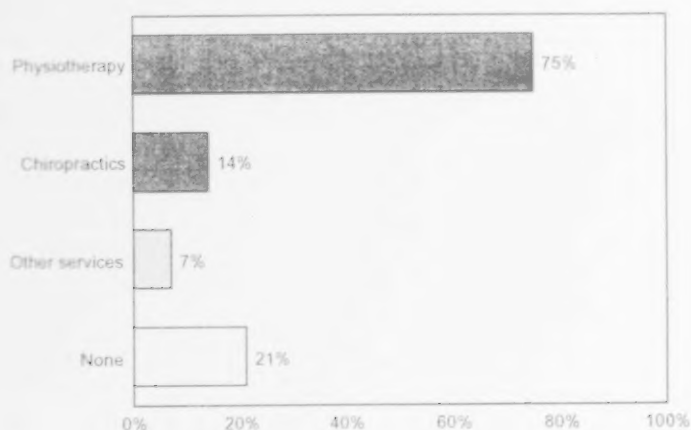


Other Pain-Targeted Services

The vast majority of FRP clients were referred for physiotherapy service by their caseworker and most were satisfied with the treatment they received. However, the majority who received chiropractic service were not overly satisfied with this treatment.

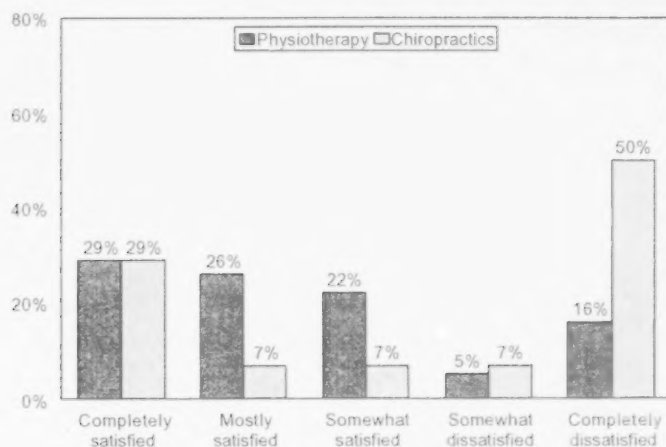
Most FRP clients are referred for some other types of services to help treat their pain as part of their program. Physiotherapy is the most common type of service, and the vast majority are satisfied with the services they received. Most FRP clients are positive concerning the effectiveness of the physiotherapy they received in terms of treating their pain.

Type of Therapy Services Received
Through WCB Referral



By comparison, while only a small minority are referred for chiropractic services, more than half are dissatisfied with the effectiveness of this treatment. This dissatisfaction, no doubt, stems from the fact that more than half do not believe the chiropractic services they received were effective in helping them with the pain they were experiencing.

Satisfaction with Therapy
Services Received for Pain

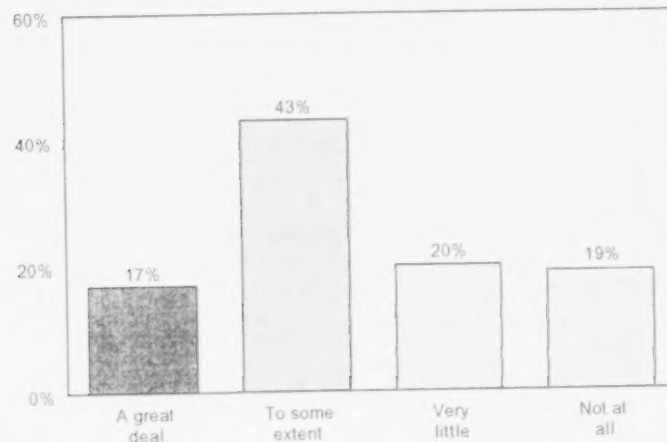


Program Impact

A majority of FRP clients say the overall program was successful in helping them deal with their pain.

Given that the objective of the Functional Restoration program is to help injured workers manage the pain and pain-related symptoms as the determinants limiting a return to the workplace, a main measure of success of the program is the extent to which it helps clients with their pain. Six in ten clients say the program, including counselling sessions and other services provided through the WCB were helpful overall in dealing with the pain they were experiencing, while a sizeable minority are more negative concerning the effectiveness of the program.

To What Extent Did the Program Help You Deal with Your Pain?



A slim majority of FRP clients did not return to work shortly after the program, but the majority report being currently employed.

Although the FRP does not guarantee a return to work, it was established to assist clients in the management of their pain and pain-related symptoms as the factors limiting a return to work. Given this objective, an indicator of the success of the program is the return-to-work status of clients. More than half of clients did not return to work shortly after the completion of the program.

Virtually all of the clients who returned to work after the program did so for the same employer, and most returned on a full-time basis. Diminished capabilities did not seem to be the case for those clients who returned to work after the program as the majority returned to the same type of job they had prior to their accident.

Current employment outcomes are more positive, as nearly six in ten FRP clients report being presently employed. Most clients are currently working for the same employer they had before the accident that left them injured, and the great majority are working in a full-time capacity. Most clients currently working are doing the same type of job, and are twice as likely to be employed in a totally different job than those who returned to work shortly after the program.

Overall, clients who participated in Phase I only or both phases of the program believe it to be more effective and are more inclined to be satisfied.

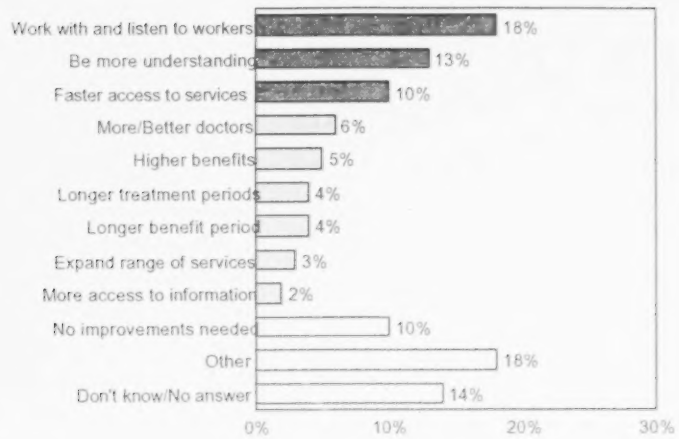
The data reveals that, on the whole, clients who completed Phase I only or both phases of the program are more inclined to rate it more positively, while those participating in only Phase II are more critical concerning the program. Clients who participated in both phases of the program are more positive regarding their experiences with the case worker, the level of counselling sessions they received, and the extent to which the sessions helped them understand their pain and achieve positive outcomes. Generally, Phase II only participants are more inclined to rate the program negatively concerning these aspects of its delivery. This may be due to the fact that the program is more effective when clients participate in both phases, and that Phase II is not effective as a stand-alone program.

Recommendations for Improvement

Clients do not identify any areas of service that are in critical need of improvement, but the most common recommendations pertain to listening to clients, being supportive, and faster access to services.

A good measure of how clients feel about their experience in the FRP program is what they have to say when asked what, if anything, they think could be done to improve the assistance and services that are provided to injured workers to help them deal with their pain. When asked this question (without prompted responses), what is obvious is that there are no specific types of improvement or change identified that might suggest problem areas. Clients are more likely to identify issues pertaining to communication and emotional support than specific aspects of the program. Clients are most likely to say the WCB can improve services by working with and listening to their clients, being more understanding and supportive, providing faster access to services, provide access to better doctors, or a number of other types of improvements, but none by as much as five percent of clients. Moreover, one in seven of the clients could not identify anything they thought the WCB could do to improve the services it provides to injured workers, and one in ten said there was no improvements to make.

How Can the WCB Better Assist Workers Deal with Their Pain?



APPENDIX F: FRP Evaluation Report of Psychologists' Survey

FRP Evaluation:

Report of Psychologists' Survey

Results and Discussion

Psychologists who responded to the FRP evaluation survey were satisfied with, and supportive of, the program, they believed that workers benefited from the counselling services yet they identified changes to improve the program. All of the 41 psychologists who are approved by the WCB to offer FRP counselling services were sent a FRP evaluation questionnaire. Twenty-four questionnaires were completed and returned, for a response rate of 59%. Half of the respondents (50%, 12) were from the Halifax Regional Municipality and there were four respondents (17%) each from South Shore/Valley, Cape Breton and the Central/North Shore regions. The majority of the responding psychologists (79%, 19) had received Functional Restoration Program referrals.

Psychologists reported high satisfaction levels with the FRP information package and with the FRP training provided by the WCB. Most psychologists (96%, 23) recalled receiving the information package that was sent to them and the majority (86%, 19) were satisfied with the information provided. Fewer (58%, 14) psychologists attended the FRP training session: most respondents (92%, 12) were satisfied with the FRP training provided by the WCB and of those who did not attend, 78% (7) expressed interest in attending one. Many (71%, 12) psychologists were interested in attending a follow-up/refresher session. Psychologists reported that the session was clear, well organized, informative and comprehensive. They were pleased to meet WCB personnel, to have the expectations of psychologists clarified and with the opportunity to ask questions. Psychologists' responses included the following:

- *The clear way the program was explained. The opportunity to ask questions and exchange comments with other practitioners.*
- *Krista Connell presented a well organized thought out program based upon clinical efficacy and proven methods.*

Psychologists are looking for opportunities to meet and discuss issues associated with chronic pain both with their colleagues and with WCB personnel, and to share their successes and problems, especially now that most have now provided FRP counselling. Also, they expressed an interest in finding out

about the effectiveness of the program in terms of workers outcomes and WCB counsellors' perspectives of workers' outcomes.

- *Discussion time for psychologists to discuss successes and problems. Feed back from WCB intake counsellors.*
- *Evaluation focus re: effectiveness of program.*

Psychologists were generally pleased with their communication with the WCB but less satisfied with WCB's expectations of psychologists and with the information provided them in the referral process. Eighty-six percent (19) were satisfied with the information about the mission/responsibility of the WCB and with the information provided about the FRP. Most (91%, 20) respondents clearly understood the standardized rate of reimbursement. More respondents (73%, 16) were satisfied with the information provided regarding the maximum number of counselling sessions approved for Phase I than with the information about maximum number of sessions recommended for Phase II (67%, 14). Nearly ¾'s of respondents (73%, 16) were satisfied with WCB's expectations for them as a FRP service provider and for their initial assessment report. Respondents reported slightly lower satisfaction levels (68%, 15) with WCB's reporting requirements for progress reports and for their final discharge reports.

All psychologists who received FRP referrals (100%, 19) reported that it was clear that referrals were for FRP counselling services. However some psychologists (26%, 5) reported never receiving the FRP Psychological Services Referral Form, one rarely received it (5%), 32% (6) sometimes received the form and only 37% (7) most often received the form. Clearly the FRP Referral Form is not consistently used by WCB staff for all FRP referrals.

Psychologists were not satisfied with the information provided them by the WCB regarding the referred injured workers. The majority of psychologists were dissatisfied both with the information provided in the referral process about injured workers' case plans (50%, 11) and medical histories (59%, 13). Fewer than half the respondents (47%, 9) felt that the WCB provided sufficient information about the needs/background of injured workers. Psychologists stated they required the date of injury, medical intervention, recommendations of specialists, and the needs/background for referred workers. Also, one respondent reported receiving the FRP Referral Form after a worker had already received a

psychological counselling session. If WCB case workers had consistently completed and forwarded the FRP Referral Form to the psychologist at the time of the request for a referral, this information would have been provided.

- Sometimes sufficient info. doesn't always accompany the FRP referrals, however when requested, info. is provided.
- Usually, but at times the information is sketchy and the timing of the information precludes addressing these issues, e.g. receiving a referral during the first week of FRP II, which does not allow a session to be set until the following week or so.
- In the referral material focus is on the medical aspects of the client. Little or nothing is given re: needs/background.

Psychologists reported that appropriate workers were referred for counselling however they were less satisfied with the timing of Phase I referrals and with the information provided to workers for Phase I counselling. Most psychologists (95%, 18) reported that WCB case workers referred appropriate injured workers for FRP Phase I counselling services but fewer were satisfied (63%, 12) with the timing of the referral for the prevention of chronic pain: FRP Phase I. Most psychologists (84%, 16) felt that appropriate workers were referred, and at the appropriate time, for the management of chronic pain: Phase II of the FRP. Psychologists were slightly more satisfied with the information WCB provided injured workers about the counselling services they would receive in Phase II of the FRP (74%, 14) than with the information provided workers about what to expect from Phase I counselling services (63%, 12).

The majority of respondents (68%, 13) reported a need to change the referral process. The suggested changes included the need to provide more information to the injured workers about why they were being referred for psychological counselling, the benefits of the program and what to expect from the pain-related counselling. Also, several psychologists suggested that case workers should anticipate a longer lead-time (perhaps 2-3 weeks) for the first psychological counselling appointment.

- Clients didn't seem to understand why they were being referred so precious time was spent explaining and reassuring. Perhaps the worker could spend more time educating them prior to referral?
- More information about services to clients [and more information] about clients to psychologists.
- Very few clients knew even that they are in FRP and what the next step after FRP might be i.e. That it is time limited. FRP II is much too short, one has hardly begun if this is the first referral, and clients need time to synthesize and practice materials, therefore I would never give 3X weekly sessions, and rarely 2X weekly

sessions.

Overall, 84% (16) of respondents were satisfied with the FRP. All (100%, 19) psychologists believed that injured workers benefited from the psychological services provided them during Phase I of the program and the majority (79%, 15) were satisfied with the number of sessions funded in the first phase of the program. Most psychologists (84%, 16) believed that the current approval limit of 12 counselling sessions for Phase I of the FRP was appropriate early intervention for the prevention of chronic pain. Psychologists indicated that while 12 sessions was adequate for most injured workers, there were a few cases where additional sessions would have been beneficial. More than half (67%, 12) of the psychologists reported that they saw injured workers who wanted or needed more than 12 counselling sessions yet less than half (42%, 5) of those workers continued on with the additional sessions. Two respondents reported that workers did not have the financial resources to continue with counselling sessions. One respondent reported that approval for additional sessions was provided by WCB. One other psychologist was not aware of the approval limit for Phase I counselling sessions.

Psychologists made suggestions for Phase I of the FRP. These included the need for: earlier referrals; consistent use of the referral form; the provision of more complete information when making a FRP referral; better communication between physicians, case workers, physiotherapists and psychologists; combining psychological counselling with physiotherapy; flexibility in the number of sessions permitted. Also, one psychologist suggested that a workshop for injured workers would be beneficial so those workers could share their experiences. Finally, one respondent suggested there was a need to reduce the stigma associated with seeing a psychologist and to educate doctors to have a positive influence on their patients.

- *(1) Earlier referral; (2) extend program by 2-3 weeks; (3) encourage all service providers (psychologists, doctors, physiotherapists) to communicate with each other; (4) encourage WCB to use the referral form.*
- *Appropriate literature exploring the benefits of chronic pain program i.e. Testimonials, any effort to reduce the stigma of seeing a "shrink". Also a progressive campaign to educate doctors would be helpful as they can have a positive influence on their patients.*

Respondents were less satisfied with Phase II of the FRP. Fewer respondents, yet still a clear majority, (79%, 15) reported that workers benefited from the psychological counselling provided in Phase II and

fewer (68%, 13) were satisfied with the funding provided by the WCB for sessions in Phase II. All respondents (100%, 18) indicated that the approval limit of four weeks was inadequate for the management of chronic pain. Seventy-nine percent of respondents (15) indicated that they had workers who wanted or needed further counselling sessions in FRP Phase II. Again the lack of financial resources was cited as a barrier to receiving additional counselling sessions.

There was a consensus among respondents that FRP II needed to be extended beyond four weeks however the time required to manage chronic pain varied. Psychologists believed that many injured workers referred for pain counselling had many issues to be dealt with and workers do not benefit from more than one session per week. They suggested that Phase II of the FRP should be extended beyond four weeks to permit an adequate number of weekly sessions to address workers' pain-related issues. Many suggested permitting the same number of sessions (i.e. 12) but over a longer period of time. Others felt that between 6-8 weeks would be appropriate for Phase II.

Although 4 weeks is quite sufficient for most individuals, some clients would benefit from further support and encouragement.

- *Too short - #1 session for assessment, #2 for review of results and start up, #3 for actual counselling, #4 for close up!! It is not beneficial to see a client 2-3 times a week.*
- *These clients do not like to get involved because they feel there is no reason as it will end soon. The therapeutic relationship thus is not a very supportive one.*

Psychologists advocated for a more coordinated and integrated provision of pain-related services for the prevention and management of chronic pain. Better communication between service providers would address this issue. Also, WCB case workers could assist by providing psychologists completed referral forms, in advance of the first counselling session, when requesting psychological counselling services.

- *In some cases not all relevant services are coordinated. Do service providers or all parties involved ever get together as a team?*

Generally speaking, the FRP was highly rated by psychologists and for the most part they are satisfied with the program.

- *The FRP is a useful approach to treatment but injured workers are often confused about what the program is for and are fearful of having benefits terminated and frequently need to address this during treatment time. Hence, treatment time for pain is sometimes involved. Extending the duration of FRP I by 2-3 weeks and FRP II by 4 weeks would be helpful.*
- *I believe the Functional Restoration Program is a success and a very useful and beneficial service for the injured worker. For the most part, it's been my experience that the worker benefits greatly as they are very often distraught and confused when consumed by pain. Counselling not only provides an outlet for feelings, but offers support and encouragement for a gradual restoration of balance and a return to work. It is been very rewarding to assist clients during their recovery.*
- *I have found that the WCB intake counsellors are very efficient and pleasant to speak with. They are always friendly and caring with regard to their clients. I have heard many positive comments about these women (I have not had an intake male yet!). Good work!*

Recommendations

Training and Follow-up Sessions:

Consider offering a training session for those psychologists who have not received FRP training. Also, a follow-up session would be beneficial for those psychologists who have received the training. If training or follow-up sessions are offered, updated information about the FRP, a clear outline of expectations for psychologists, along with the results of the program evaluation should be provided. Opportunities for discussion of the issues associated with chronic pain, for exchange of experiences and for asking questions should be provided in FRP-related sessions.

Clear Expectations for Psychologists: Reporting Requirements and Service Standards

It would be helpful if the WCB were to clearly outline their expectations for psychologists' reporting requirements and service standards. Also, psychologists should advise WCB if a worker withdraws from counselling services. Perhaps a follow-up letter outlining these would be beneficial for psychological service providers.

Use of FRP Psychological Services Referral Form:

Consistent use of the FRP Psychological Services Referral Form is recommended for all FRP psychological counselling referrals. It may be useful to fax the FRP Psychological Services Referral Form at the time the request for psychological counselling is made. This would enhance communication with psychologists and ensure that they are provided with the necessary information about the injured worker's case plan, medical history and the pain-related needs of the worker to enable psychologists to develop treatment plans.

Explanation of Purpose of the FRP, Benefits of Psychological Counselling, What to Expect:

It may be necessary for WCB staff to spend time with workers outlining the purpose of the FRP, the benefits of counselling, and what to expect from the pain-related counselling, especially for Phase I counselling services. Perhaps the form letter advising the worker of FRP services could be revised to include more information about why the worker is being referred, the benefits of the program, and what to expect from the counselling sessions. The letter would reinforce case workers explanation of the purpose (either the prevention or management of chronic pain), the benefits and what to expect from FRP counselling services.

Guideline for Number of Counselling Sessions in FRP Phase I:

While 12 sessions is adequate for most workers in Phase I of the FRP, there are some workers who would benefit from additional sessions therefore WCB should provide funding for additional sessions when there is a need. Perhaps the approval limit of 12 sessions should be considered a guideline rather than a rule.

Referral of Workers for Phase I Counselling Services:

Earlier referral of workers for Phase I of the FRP should be considered. Perhaps Phase I should be considered by WCB staff at the required 45-day case review.

Time Frame for FRP Phase II:

Since psychologists believe that workers benefit from weekly counselling sessions and do not feel that four sessions are adequate for the management of chronic pain, the WCB should consider referral of workers for Phase I services prior to entering Phase II to improve counselling outcomes for workers.

Service Provider Communication:

The WCB should consider strategies to improve communication among service providers to facilitate a more integrated treatment plan for injured workers. Perhaps a generic referral form, similar to the form used for FRP Psychological Counselling Services, could be developed and used for all service requests to address the communication issue. Other methods to facilitate sharing of information should be considered.

APPENDIX G: FRP Evaluation Report of Staff Survey

FRP Evaluation: Report of Staff Survey

Results and Discussion

Response Rates

Forty five of a possible 60 staff members responded to the survey, for a response rate of 75%. Of the 44 respondents who identified the ISU for which they worked, 16 (out of a possible 21) were from the Halifax Regional ISU (76% response rate); 11 (out of a possible 14) were from the South Shore/Valley ISU (79% response rate); all 13 eligible staff members from the Cape Breton ISU responded (100% response rate); but only four of the 12 Central/North Shore ISU staff members who were sent a questionnaire responded (33% response rate).

Training

Many respondents attended the formal FRP-related training sessions. Almost 3/4s of respondents who have a direct involvement with the FRP (71%, 32) received the two-day training session held in the spring of 1996. At least half of the respondents attended the normal recovery times follow-up session in the fall of 1996 (51%, 23) and the introduction to psychology session in 1997 (62%, 28).

Fewer respondents reported receiving informal training. Only 29% (13) received on the job training for their current position and only 7% (3) reported job shadowing for their current position. Three respondents reported receiving other training: one received employment support worker training, one received Adjudication Advisor training and one staff member reported receiving the Staff Progressive Module.

Most respondents (82%, 37) felt they had enough training to make or approve referrals for FRP services yet almost half (42%, 19) of the respondents indicated a need for more FRP-related training. Several respondents committed that a refresher/review/update on a yearly basis may be of benefit:

- *Refresher on subject, & review of forms & screens we need to complete.*
- *Process for total program should be reviewed yearly with users.*

Suggestions were also provided on specific material that should be covered in training. One respondent wanted information on normal recovery times, another wanted more specific information about what takes place during the psychological counselling, and another wanted more in-depth information to help determine when is the best time to offer the FRP. Another respondent requested clarification of the role of the Medical Advisor. A yearly FRP update session may address these needs.

Overall Satisfaction with the FRP

While many respondents were in some way dissatisfied with the FRP, most felt that the WCB should continue to offer both Phase I and II of the FRP. The majority of staff (56%, 20) was satisfied with the FRP. Some respondents questioned the efficacy of psychological counselling for the treatment of chronic pain, others reported that many workers refused FRP services, and some wanted the program simplified. Other respondents saw workers benefit from the pain-related services and were helped return to work. Most respondents indicated that the WCB should continue to offer both Phase I (84%, 27) and Phase II (79%, 27) of the FRP.

FRP Referrals

Most survey respondents (84%, 38) had made FRP referrals. Of the seven who had not referred injured workers to the FRP, three indicated their case load did not include workers who met the FRP criteria, and each of the following reasons for not referring to the program was cited by one respondent: not familiar with the FRP, do not understand the FRP, the referral process was too complicated, and one other reason (case managers refer). Lack of psychological service providers was not a reported barrier to referring workers for FRP services.

Staff was asked to indicate how difficult/easy it was to determine whether workers met the FRP criteria and whether or not the criteria should be changed. About 3/4s of respondents found it easy to identify workers who are eligible (76%, 29) and applicable (74%, 28) for Phase I of the FRP but fewer (63%, 24) reported it easy to identify suitable workers for Phase I of the FRP. More respondents reported that it was easy to identify workers who are eligible and applicable (82%, 31) and suitable (76%, 29) for Phase II services. Twenty five percent (8) of the respondents indicated a need to change the criteria

for Phase I while only 6 % (2) felt there was a need to change the criteria for Phase II. Respondents who had difficulty determining who met the Phase I referral criteria indicated they had trouble distinguishing between applicability and suitability categories and that many of the questions in these categories were difficult to answer. Also, respondents indicated that in some exceptional cases the eligibility criteria of 12 months was too short. The following are comments about recommended changes to the criteria used to identify workers for Phase I of the FRP:

- *Eligible/applicable sounds like they mean the same thing. If a worker is eligible they have already been deemed to be suitable – I suggest that one question instead of these. Categories (eligible, applicable, suitable) are complicated.*
- *Staff does not seem to identify workers eligible for Phase I early enough in the claim. Should be a mandatory checklist completed early in the claim (possibly 45 days) to help identify flags. Check list could be done again later in the claim (? 12 weeks). This could help case owners identify workers for Phase I and ensure timely referrals.*
- *Should be exceptions when Phase I can be used after 12 months, post injury.*

A further analysis of the above indicated that workers who had not received the two day FRP training session had more difficulty identifying workers who were eligible, applicable and suitable for the FRP than respondents who attended the FRP training session. In Phase I, 37% (3 out of 8) of respondents who had difficulty determining who was eligible had not attended the two day FRP training; 42% (3 out of 7) of those who had difficulty determining who was applicable had not received the training; 55% (6 out of the 11) of those who had difficulty determining who was suitable did not receive the FRP training. Similar patterns were observed for Phase II: 50% (2 out of 4), 40% (2 out of 5), and 50% (2 out of 4) of respondents with no FRP training reported difficulty identifying workers who are eligible, suitable and applicable (respectively) for the second phase of the FRP. While it was not possible to test these responses for statistical significance, due to the small (less than 5) response categories, it is reasonable to assume that lack of FRP training, along with complex criteria categories (especially applicability and suitability) contributed to staff's difficulty in identifying workers who are appropriate for the FRP.

Staff was asked how difficult/easy it was to get pain-related services for workers. Some difficulty was experienced in obtaining psychological counselling services, with more respondents (42%, 16) experiencing difficulty in obtaining Phase I psychological counselling services than Phase II services

(37%, 14). The greatest difficulty in obtaining psychological services for both phases of the FRP was reported in the South Shore Valley ISU (75%, 16 respondents from that ISU), followed by Cape Breton (63%, 5) and Central/North Shore (50%, 2). Respondents from the Halifax Regional ISU reported little difficulty (19%, 3) in obtaining psychological services. Little difficulty was experienced in obtaining other Phase II pain-related services: physiotherapy was the easiest to obtain (87%, 23), followed by work conditioning (76%, 29), work hardening (63%, 24) and chiropractic services (61%, 23). It appears that it has been more difficult to obtain psychological services, especially in the South Shore/Valley, Cape Breton and Central/North Shore ISUs than other pain-targeted services.

Staff was also asked about the FRP referral process. Sixteen percent of respondents (6) reported difficulty in obtaining approval from their Medical Advisor for Phase I and II referrals (16%, 6 for both phases) and no respondents had difficulty obtaining approval from their Adjudication Advisor for FRP Phase II services. Slightly less than one in five respondents reported dissatisfaction with the referral process for Phase I (16%, 6) and Phase II (18%, 7) of the FRP yet more (Phase I: 29%, 10; Phase II: 34%, 12) indicated that changes were required for the current referral process. The consensus among respondents was that given the role of Medical Advisor for FRP referral approvals was not well defined or necessary, it should not be required and, in fact, the need for this approval may take away from Case Workers credibility.

- *What is role of MA besides signing off for undefined reasons?*
- *I believe we as case owners should start the process ASAP as soon as there is any indication of chronic pain.*
- *I am supposed to offer to worker, get approval and then confirm with workers. This really takes away my credibility! (at Case Management level).*

Generally speaking, most respondents who commented on the Phase II referral process indicated that while approval for referral for Phase II services may be necessary, the need for approval of both the Medical Advisor and the Adjudication Advisor should not be required. Staff indicated that the need for two signatures tended to cause delays in the referral process for Phase II services and the solution was to require only one signature.

- *A sign off here is a bit more important because we are saying that there is no more case management warranted but one signature should be sufficient either AA or Medical Advisor.*

- *Phase II shouldn't require sign-off from the AA as well as the Medical Advisor. This takes up more time of the Case Worker and slows down the process which should be done as soon as possible.*
- *Getting the two signatures can sometimes be troublesome – may result in a delay – one sign off would be better.*

A preliminary analysis of the program participation rates revealed that workers were sometimes completing Phase II services without completing Phase I, as initially planned. Respondents were therefore asked to provide situations where they would refer workers for Phase II only services. The most common response was that when there were no longer any significant objective physical findings that prevented the worker from returning to work yet the worker cited pain as a barrier to returning to work. Another theme among respondents was that the worker would generally not be referred for Phase II only services unless the worker refused Phase I services. Finally, some respondents indicated that they might refer for Phase II only services when the return to work plan had failed, pain was the only barrier to a return to work, and it was the only remaining service left to offer the worker.

- *Beyond the normal recovery period. No significant objective findings of disability which would indicate the injury has not healed. Pain – the main barrier to RTW.*
- *When it is obvious that pain is the barrier to RTW. All other medical investigations have been carried out and there is no objective findings to support pain.*
- *Usually have to give FRP II to injured workers whose claims are closing but are not returning to work. They may not have a job to return to, for example, but insist they still have pain. They would therefore get Phase II but would not have gotten Phase I.*
- *When a RTW plan has failed, there is no medical justification to continue TERB. The plan prior to had not suggested FRP was appropriate. Also, worker refused FRP I – they will accept II because of benefit (TERB) extension.*
- *The only instance a worker would be referred for Phase II only is if the worker had refused Phase I and accepted Phase II following discussions re: claim closure.*
- *I wouldn't. I always refer to Phase I before referring to Phase II. Sometimes, I use the period for advance notice of claim closure (2 weeks) as the Phase I period then initiate Phase II after the 2 weeks for claim closure has expired.*

These responses suggest that it may be difficult to recognize the signs that would indicate the potential development of chronic pain before it is actually present, to determine when the worker who is within the normal healing time is a candidate for the development of chronic pain; and it may be difficult to determine when workers who are within the normal recovery periods exhibit pain that is becoming

prominent as a limiting factor in the return to work process (i.e. it may be difficult to determine when pain is becoming prominent until it becomes prominent). One respondent confirmed the suspicion that it is difficult to identify workers for Phase I of the FRP:

- *It is difficult during the acute stage of an injury to differentiate between "normal" pain and pain that is out of proportion to the precipitating injury.*

Staff was asked how they choose a FRP psychological service provider. For many respondents, there was no choice: they refer to the only approved psychological service provider in their area or to one who is willing to travel to their area. When choice of providers was an option, staff chose psychologists who demonstrated success by providing workers with effective treatment; who were reliable and provided timely reports; who were reasonably available; who encouraged the worker to return to work and provided coping strategies; and one who did not suggest retraining for workers. Staff have also permitted workers to choose the service provider since in some cases workers did not want to attend counselling sessions in their home town or requested a psychologist of a particular gender.

- *I only have one psychologist in my entire area and she actually travels there at my request. Choosing is a luxury I don't have.*
- *By location mainly, also male vs. female if client has a preference; also history, if I've had some success with a particular psychologist will use more (& vice-versa).*
- *I choose by my experience of who has assisted injured workers the best.*
- *I seek out someone who is going to encourage the worker to RTW, provide coping strategies. I stay away from psychologists who encourage disability, withhold reports for long periods of time. This comes from experiences in the past.*
- *Try to use those who have had some success in the past and who provide useful reports.*
- *(1) Availability; (2) ability to continue treating client for full treatment period; (3) feedback from workers; (4) ability to establish rapport and conform to rules and regulations of FRP program; (5) feedback from psychological counsellor.*

Staff provides background information about workers that they refer for psychological counselling. Most staff (89%, 29) provides background information about the worker's case plan and medical history (85%, 28) when making FRP psychological service referrals. However when asked to describe the type of information provided and the way it is provided there was quite a range. For example,

fewer than half of the respondents (43%, 16) indicated that they always used the FRP Psychological Services Referral Form. Descriptions of the information provided about workers' case plans varied:

- *No. Have made FRP II referrals mostly, when claim closing so no case plan future action at that point.*
- *No. I provide a description of injury and medical documentation only. This is all that's requested.*
- *Yes. Direct referrals are made and discussions with the psychologists always take place. Info about the nature of injury, current complaints the worker has, nature of the job, education are always discussed personally.*
- *Yes. I send the last couple of medical reports so they have an idea of what is happening.*
- *Yes. Briefly re: goal.*
- *Yes. I usually send a copy of case management plan (Phase I) or closure decision (Phase II).*
- *Yes. Verbal explanation to the psychologist.*
- *Yes. Sometimes I give info on case plan (i.e. RTW plans) is I think info is relevant. Clarity on what info we should provide would be helpful.*

Descriptions of information about injured workers' medical history that were provided to psychologists were also diverse:

- *No. Only initial diagnosis as requested on referral form.*
- *Injury, prognosis, diagnosis, how injury had impacted the worker's ability to perform job mentally & physically, pending surgery, previous surgery, on pain killers for long time. Drug addiction, alcohol problems.*
- *Yes. I send the last couple of medical reports so they have an idea of what is happening.*
- *Yes. In some cases - medical information will be forwarded.*
- *Yes. Details as provided on form.*
- *In serious/complicated cases.*

Not all staff members are comfortable referring workers for psychological counselling services. Fewer than half the respondents (49%, 18) reported being very comfortable, 32% (12) were somewhat comfortable, and 13% (5) were uncomfortable.

FRP Services

Staff was asked their opinions of Phase I counselling services for the prevention of chronic pain.

Respondents were almost evenly split in their opinions: 53% (17) of respondents who rated Phase I psychological counselling services considered them effective and 47% (15) felt they were ineffective. Most respondents (90%, 26, of those who rated their satisfaction) were satisfied both with the current limit of 12 counselling sessions and the \$2000 limit for Phase I expenses. Seventy two percent of respondents (21) considered 12 counselling sessions appropriate early intervention for the prevention of chronic pain. Almost one in five respondents (who provided a rating, 21%, 6) considered it difficult to make sure that FRP Phase I expenses did not exceed \$2000.

Respondents indicated that for most workers 12 counselling sessions were adequate for the prevention of chronic pain however a few workers might benefit from additional sessions. One respondent indicated that if more sessions were required, the worker would be referred to Phase II of the FRP.

- *No. In some cases it may be enough; however in other cases more would be beneficial.*
- *Yes. The idea of FRP is to get the worker other ways of coping with pain. More than 12 sessions could foster a dependency roll on the psychologists.*
- *In most cases – the claim “rolls over” into Phase II if pain continues to be the barrier.*

Respondents were asked questions about Phase II counselling services. Over half the respondents who rated the effectiveness of psychological counselling services for the management of chronic pain considered them to be effective (53%, 18). Three quarters of respondents (75%, 21) felt the current approval limit of four weeks of counselling sessions is adequate. All respondents (100%, 31) were satisfied with the current limit of \$8000 for FRP Phase II expenses and 87% (26) found it easy to make sure that Phase II expenses did not exceed the limit.

Respondents suggested that if workers participated in Phase I, then four weeks for Phase II was adequate. However, if the worker participated in Phase II only, then four weeks was not adequate.

One staff member suggested that they requested of psychologists more than one session per week but they did not “comply.”

- *Yes. 4 weeks would be adequate if psychologists would treat workers more than once per week. Even though we request more, they very seldom comply.*
- *Yes. Particularly if it is as an adjunct to Phase I completion.*
- *No. Especially if the worker has not participated in Phase I.*
- *I have had 2 occasions where the workers has only received Phase II and has received such benefit from the sessions that they are then able to participate in an ease back after Phase II completion whereas they felt incapable of doing so before Phase II. However, the way the system is now, we are not to offer anything further beyond Phase II – I think this should be looked at if an additional 2-4 weeks would make the difference between a RTW or no RTW.*

There was a clear consensus on reasons workers cited for accepting FRP Phase II services and why staff liked to offer Phase II. Staff believe that workers accept Phase II services because it extends their benefits by four weeks. Staff also indicated that Phase II brings closure to workers’ cases where pain is the only barrier to a return to work.

- *I feel a lot of workers take it only for the extra 4 weeks of benefits.*
- *It provides legislated closure on the claims. I do not feel it is effective because most of the injured workers who avail of this are those who are not returning to work for economic reasons. Their “pain” simply gives them another 6 or 8 weeks of benefits.*

Staff reported several reasons for workers not accepting or withdrawing from Phase I and/or Phase II of the FRP. Workers reasons for not accepting FRP services were varied: they did not want to sign the “release of information” form; some workers were offended by the offer of psychological counselling and by agreeing to see a psychologist was an admission that the pain was “all in their head” and that they were “crazy”; some were afraid of getting psychological counselling; some had good social support; others indicated that they did not require assistance: that they were handling pain well on their own; some indicated that there was still something physical causing their pain and were waiting to see another specialist; some feared the stigma/label associated with psychological counselling; and others returned to work. According to staff, workers withdrew from the FRP because they felt the process was too intrusive; some returned to work on their own; some felt counselling was not appropriate or

effective for them; others didn't like the psychologists' approach (i.e. discussion of childhood; dream therapy, relaxation techniques); and others indicated they were in too much pain to attend sessions.

- *Workers decline FRP I generally because they feel that there is something specific causing their pain, often they will wait until following a specialist appointment and when all is o.k. with injury then they may accept.*
- *People will think I'm crazy. I don't need a shrink. I'm doing o.k. on my own. You think "I'm faking my pain."*
- *They don't want to be labeled as needing "counselling".*
- *Many resent what they feel is the implication their pain is "in their head". They search for a physical solution to explain the degree of pain suffered.*

It may be that the FRP is particularly effective when workers are motivated:

- *It has been of great help in a few cases, usually clients who truly want to be helped.*
- *The more active and devoted the worker is to a positive outcome, the better results will come forth.*

Staff reported inconsistent receipt of psychologists' reports. Of those who received reports, the initial assessment report was most often/always received (61%, 22) followed by the final discharge report (56%, 20). Only 38% (14) of respondents most often/always received progress reports. Comments about psychologists' reports indicated that reporting was inconsistent, highly variable, and sometimes contained irrelevant information.

- *Quite often I have to call and request reports.*
- *Some psychologists feel they only need send a report at the end of the treatment.*
 - *Appears to be highly variable in detail and quality.*
 - *Standard Form would be great then psychologist would not make retraining recommendations.*
 - *Should stick to issues pertinent to injury and its effect on worker's life and the treatment being offered, results expected, and results to date.*

Staff was also asked to rate the effectiveness of other pain-related services. Among respondents who rated the effectiveness of these services, work conditioning was considered the most effective for the management of chronic pain (81%, 30) followed by work hardening, physiotherapy and chiropractic treatment (76% 28; 65%, 24; 46%, 16 respectively). Staff indicated that workers generally are offered these other types of services during case management and therefore they are not offered these

services for Phase II of the FRP. Several respondents noted that these others services can sometimes interfere with the treatment of chronic pain.

- *Most have already been provided the service through case management, so usually they are just being sent to pain counselling.*
- *Quite often non-counselling services are done through regular case management of claim and FRP II is used only for counselling when claim is closing.*
- *Work Hardening/work conditioning; most often found to aggravate injury. Usually end up terminating program.*

Data Collection and Entering Process

Responses to the questions about data collection and entering indicate a concern for the quality of FRP-related data. The majority of staff found it easy to complete the *Pain Targeted Services Consultation, Outcome and Refusal Record Form* (77% of respondents who rated this question, 23). However, many indicated that changes were required for the form (37%, 10), some did not use the form (18%, 5), some did not know who the form was sent to for data entry (62%, 21), slightly more than half of respondents reported sending the form both after the worker accepts (or declines) services and again when Phase I or Phase II is completed (57%, 16) as described in the Procedure Manual. Furthermore, a few respondents (13%, 4) were aware of data entry problems into the AS/400. The majority of staff coded their own medical aid expenses (73%, 24) but report having trouble keeping track of FRP-related expenses (47%, 15) and only a few use the FRP Costing Form (16%, 5) to keep track of expenses. Many staff indicated that they used an informal tally at the back of the worker's file to track FRP-related expenses.

Recommendations

Annual FRP Training

Consider offering a yearly training session to review the FRP. A review of the purpose and objectives of the program, outlining related policies and procedures and clarifying the processes that should be followed would ensure that every staff member who is directly associated with the program is familiar with the program.

Simplify the Criteria Used to Identify Workers for the FRP

It is recommended that the criteria used to identify workers for the FRP be simplified, especially the suitability criteria for Phase I of the FRP. This would help staff refer appropriate workers for FRP services.

Eligibility Period of 12 Months: a Guideline

There may be exceptional cases where workers beyond 12 months from their date of earnings loss would be appropriate candidates for the FRP therefore it may be necessary to consider the criteria used to determine who is eligible for the FRP as a guideline rather than a rule. However, the current FRP-related Regulation does preclude workers from the program "if more than twelve months have elapsed since the worker's date of injury" and therefore it may be appropriate to offer counselling and other pain-related services outside the FRP if the worker is not eligible for the program.

Identify Eligible Workers Earlier

It may be that we need to identify workers earlier in the claim to ensure that they receive timely referrals for chronic pain services. Perhaps all workers should be considered for Phase I of the FRP at the 45-day case review date

Increased Access to Psychological Counselling Services

While it may be difficult to increase the availability of service providers in all regions, staff could be reminded that workers are permitted to travel to Halifax to receive the psychological counselling. It may be necessary to increase the medical aid expenses permitted for travel to obtain pain-related counselling services. Another alternative may be to offer additional remuneration to psychologists willing to travel to under serviced regions of the province.

Eliminate Medical Advisor Approval for Referral of Workers for Phase I and Phase II Services

Consideration should be given to permitting Case Workers to refer workers to Phase I of the FRP without the need for the approval of the Medical Advisor and only require the approval of the Adjudication Advisor for Phase II services. This approval process should proceed the offering of the FRP services. This would avoid the delay in offering pain-related services for the prevention of chronic pain and enable Case Workers to offer appropriate services when they meet with their clients. The elimination of Medical Advisor's approval for both phases is recommended for a number of reasons: obtaining their approval causes delays in the referral process, the worker's family physician already approves of FRP services and their current role in the referral process is somewhat redundant.

FRP Psychological Services Referral Form

The FRP Psychological Service Provider Form should be consistently used for all FRP psychological counselling service referrals. The Form should be included in the Procedure Manuals and staff should have a clear understanding of the information that should be provided on the Form.

Generic Referral Form

It may be necessary to revise the FRP Psychological Services Referral Form so that it could be used for all referrals to FRP service providers. That would ensure that service providers have relevant information about the worker so they can deliver services to meet workers' needs.

Referral of Workers for FRP Phase I Services

Since staff find it difficult to identify workers who might benefit from Phase I of the FRP, it may be necessary to expand the current criteria. This would: (1) make it easier to identify potential participants for Phase I of the FRP; and (2) include more workers who might benefit from a pain-targeted program.

Phased Approach to the FRP

Based on psychologists' and staff survey results, some changes should be considered for Phase I and Phase II of the FRP. Psychologists do not feel that workers benefit from more than one session per week therefore they suggest that Phase II be extended, and they indicated that staff are not identifying workers early enough for Phase I. Staff confirmed they are having difficulty identify appropriate workers for Phase I and analysis of participant data would suggest that Phase I is underutilized. Therefore consideration should be given to the following options: (1) lengthen Phase II for those who did not receive Phase I; (2) combine Phase I with Phase II, to avoid identifying of workers to prevent chronic pain yet offering the program to workers where pain is the limiting factor to their return to work; or (3) provide staff with revised and simplified eligibility/applicability/suitability criteria so that more appropriate referrals can be made for Phase I services and ensure that workers are referred for Phase I services prior to Phase II services: generally, only those workers who experience chronic pain and who completed Phase I should be referred to Phase II services. Given that injured workers who participated in the program were generally satisfied with the design of the program, it might be best to consider option (3) which is essentially full implementation of the FRP as planned.

Current Limit for Phase I Expenses

Because staff experience difficulty monitoring FRP expenses, it may be necessary either to (1) encourage staff to use the FRP expense form or (2) develop another mechanism that would

enable staff to manage FRP expenses.

Psychologists' Reports

The WCB may need to consider whether initial, progress and final reports are required for all FRP participants. Whatever is decided upon should be conveyed to staff so they know what to expect and to psychologists so they understand what is expected of them. Furthermore, if the expectation is that these reports are required, consideration should be given to withholding payments of invoices for psychological services until all reports are received. Finally, it may be helpful to develop a standard report form, similar to the Physician's Form 8/10, so that psychologists could provide the required information.

Assist Staff to Become More Comfortable Offering Psychological Services

Since not all staff are comfortable offering psychological services and not all staff attended the Psychological Services training session, it may be necessary to offer training or follow-up information sessions to help staff become knowledgeable of psychological counselling services and to assist with their comfort in offering such services.

Quality Data

Based on respondents inconsistent use of the FRP data collection forms, not knowing when to send the data form or to whom they are sent if sent at all for data entry, it is recommended that a new process be developed for collection and entering the data. It is suggested that the FRP Pain Targeted Services Consultation, Outcome and Refusal Record Form always remain on the file. A photocopy of the form should be forwarded to the data processor/utility assistant (whoever is responsible in the ISU for data entry into the AS/400) (1) when the worker accepts and begins a Phase of the FRP (or worker declines the offer) and (2) again when the worker completes the Phase. This would ensure the original document remains on the worker's file and would provide a check to ensure quality data. All staff involved with the FRP should be made aware of this process.

Tracking Form/System for FRP-related Expenses

Since very few staff use the FRP Costing Form and many find it difficult to keep track of FRP-related expenses, either staff should be made aware of the form and encouraged to use it or another system should be developed and implemented.

**COMPENSATING FOR
CHRONIC PAIN**

2000

COMPENSATING FOR CHRONIC PAIN - 2000

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INTRODUCTION

As there have been a number of recent studies and documentation regarding chronic pain, this document will concentrate on the approaches taken by workers' compensation boards and commissions (WCBs or jurisdictions) on handling chronic pain.

The Ontario Workplace Safety and Insurance Board (WSIB) has recently completed an in-depth study of chronic pain. A copy of the full text of the third report for the WSIB's Chronic Pain Initiative, the Report of the Chair of the Chronic Pain Panel, can be found on the WSIB's web-site at www.wsib.on.ca.

The Workers' Compensation Board of Nova Scotia is currently awaiting the outcome of two cases involving chronic pain appealed to the Nova Scotia Court of Appeal. The Court of Appeal's decision was expected at the time this publication was finalized.

A table has been included at the end of this report that summarizes chronic pain approaches at each workers' compensation jurisdiction. Appendix A contains a list of contact names at each WCB for those readers who require additional information relating to a specific workers' compensation jurisdiction.

Information from WCBs included in this report is that in effect as of September 1st, 2000.

CHRONIC PAIN AND WORKERS' COMPENSATION JURISDICTIONS

Many workers' compensation jurisdictions in Canada have enacted policies that address the issue of chronic pain. An examination of the various approaches is provided.

A. ALBERTA:

In Alberta, a formal Adjudicative Guideline for handling chronic pain cases was piloted from 1991 to February, 1997. On February 15, 1997 the Board of Directors adopted those principles into approved policy. This policy was further amended, effective August 1, 1999.

This policy applies only to chronic pain and chronic pain syndrome when pain and pain behaviour is inconsistent with organic findings. It does not apply to cases of persistent, lingering pain due to a discernible organic diagnosis or a psychiatric condition. However, other pain disorders may be categorized under a number of different labels (e.g., somatoform pain disorder, fibromyalgia, etc). Individuals diagnosed with such disorders *may* be compensated under this policy, but only if they meet the requirements for chronic pain or chronic pain syndrome.

Chronic pain syndrome may be compensable when the following conditions are met:

- all physical medical investigation and rehabilitation treatment have been concluded;
- pain results in *marked life disruption*;
- pain and related symptoms develop as a consequence of a compensable injury or condition;
- the pain persists for six months or more beyond the usual healing time for the injury;
- complaints of pain and pain behaviour are inconsistent with organic findings; and
- pain impairs earning capacity.

Marked life disruption is determined by psychological assessment, interviews, and standardized testing; and refers to difficulty or dysfunction in the following areas:

- physical/vegetative functioning;
- affective state;
- cognitive aspects;
- vocational aspects;
- family relationships;
- social/recreational activities;
- behaviour/daily activities.

Before *marked life disruption* is assessed, clinical and vocational services must first be considered. These may include, but are not limited to: psychological counselling, vocational assessment and planning.

work conditioning, individual job search, work assessments, ergonomic assessment and aids, and training on the job.

The WCB may consider treatment for chronic pain when the chronic pain has the following characteristics:

- pain related symptoms develop as a consequence of a compensable injury or condition;
- the pain persists beyond the usual healing time for the injury;
- the complaints of pain and pain behaviour are inconsistent with organic findings; and
- pain impairs earning capacity.

When claimants are referred to pain management facilities, the WCB primarily selects facilities that are CARF-accredited. At present, these facilities include Canmore Pain Clinic, Columbia Rehabilitation Centre, and the WCB Millard Centre. The programs at these facilities are interdisciplinary in nature, and include services such as physical conditioning, relaxation training, education, simulated work activities and psychological counselling (from a cognitive behavioural perspective), over a period of 6 to 7 weeks. Teams typically consist of a physician, psychologist, occupational therapist, physical therapist, and vocational rehabilitation specialist. Staffing may vary amongst programs, depending on additional services offered in that facility (e.g., GAIT, TENS, drug reduction, etc.).

The main focus of pain management programs is to educate individuals regarding the biopsychosocial nature of chronic pain, and to teach them appropriate skills for self-managing their pain. As well, there is a strong return-to-work focus, in which vocational rehabilitation is provided to assist claimants in finding suitable employment consistent with their functional tolerances. The programs are designed not to "treat", but rather to "teach", individuals how to gain more control over their lives, so that a more productive life may be lived despite their pain.

Following completion of rehabilitation plans, claimants are assessed in two ways. First, their level of fitness for work is assessed. This may include a standardized functional capacity evaluation and vocational assessment. An assessment that the claimant is capable of gainful employment, (even at a part-time status initially), may be supported through an actual or estimated wage loss benefit.

The Chronic Pain policy applies to claimants who demonstrate difficulty or dysfunction following clinical and vocational rehabilitation efforts, or are assessed as unemployable and not amenable to further rehabilitation efforts at the time of the initial review.

To determine eligibility, the Case Manager or Adjudicator consults with the WCB and/or community physician(s) and determines whether the Board's criteria for determining chronic pain syndrome have been satisfied. If so, a referral is made to the WCB Psychological Consultant in order to confirm whether there is a *marked life disruption (MLD)*. The Psychological Consultant arranges an assessment for MLD and then provides an opinion with respect to a diagnosis of Chronic Pain Syndrome, (as defined by the Alberta WCB).

Full wage loss benefits are usually paid in cases where the worker has Chronic Pain Syndrome and is assessed as unemployable. In unique situations, such as when there are overwhelming non-compensable factors, the benefits may be apportioned. However it is unusual to have clear evidence of such factors.

Although Chronic Pain Syndrome is usually considered a temporary condition that will improve over time, there are some cases when the medical condition reaches a plateau for an extended period and it is highly unlikely there will be any improvement. In these cases, the claimant is assessed for a permanent clinical impairment, usually by a psychiatrist, using the mental impairment portion of the *Alberta Guide to Assess Permanent Clinical Impairment*.

The benefits available for claimants assessed with a permanent clinical impairment for Chronic Pain Syndrome are the same as for any other permanent disability and include a Non-Economic Loss Payment for the clinical impairment and Economic Loss Payment for the loss of earning capacity. The Non-Economic Loss Payment may also recognise other compensable conditions, such as any organic impairment.

B. BRITISH COLUMBIA:

In British Columbia, the Board's approach to chronic pain is set out in policy #22.33,15 which provides:

Psychological problems arising from a physical or psychological injury are acceptable as compensable consequences of the injury. However, there must be evidence that the claimant is psychologically disabled. It cannot be assumed that such a disability exists simply because the claimant has unexplained subjective complaints or is having difficulty in psychologically or emotionally adjusting to any physical limitations resulting from the injury.

When the existence of a psychological disability is suspected, the worker's claim file will normally be referred by a board Medical Advisor, or Rehabilitation Centre Physician, to a board Psychologist for evaluation. The board Psychologist's report will be returned to the board Medical Advisor or Rehabilitation Centre Physician who will document their resulting recommendation on the claim file.

Because of the complexity of psychological problems in permanent disability claims, they will be referred, by the Adjudicator in the Disability Awards Section, to the Senior Disability Awards Medical Advisor for review by the Board's Chief Psychologist. When an evaluation has been performed, the worker's claim file will again be reviewed

by the Board's Chief Psychologist and the Senior Disability Awards Medical Advisor for confirmation of the level of functional impairment.

Since psychological impairment is not included in the Permanent Disability Evaluation Schedule, reference may be made to the American Medical Association Guide to the Evaluation of Permanent Impairment to determine the appropriate percentage of disability.

For the policy of the board when a claim is submitted for psychological problems resulting directly from the claimant's employment without the occurrence of any physical trauma, reference should be made to #13.20 [entitled "Psychological Impairment" which provides as follows: "Personal Injury" includes psychological impairment as well as physical injury. A claim for traumatically induced psychological impairment could be accepted even if unaccompanied by any physical impairment. Psychological impairment has not been deemed to be an occupational disease. Conditions of this type however may be accepted if they are a sequela to an accepted personal injury or occupational disease.] and #32.10 [entitled "Psychological/Emotional Conditions" which provides as follows: The Board does accept claims for personal injury where the injury consists of a psychological condition or the psychological condition is a consequence of a physical injury. However, the Board has not recognized any psychological or emotional conditions as occupational diseases related to employment.].

Chronic pain problems are also acceptable if the evidence indicates that they result from the work injury. If the evidence indicates that the condition is disabling but may be amenable to treatment, it will be regarded as a temporary disability and wage loss paid in the normal way. The Board may refer a claimant with a chronic pain problem to a chronic pain management clinic, in which case wage loss is paid during the attendance. On discharge from the clinic, if the claimant still has continuing complaints the condition will not necessarily be considered to have stabilized immediately. Many claimants still require time to build up their endurance. It may therefore be reasonable to regard the condition as temporary and pay wage loss under Section 29 or 30 for a further period of time.

It is imperative to recognize that the above provisions must be read in conjunction with policy #14.00 which requires that "before a worker becomes entitled to compensation for injury under the Act, the injury must arise out of and in the course of employment".

Section 29 of the *Workers Compensation Act*, as indicated above, addresses *temporary total disability*. Further, section 30 of this Act addresses *temporary partial disability*. Both of these sections are reproduced below:

29(1)Where temporary total disability results from the injury, the compensation must be the same as that prescribed by section 22, but is payable only so long as the disability lasts.

29(2)The compensation awarded under this section shall not be less than an amount equal to \$75 per week, unless the worker's average earnings are less than that sum per week, in which case the worker must receive compensation in an amount equal to the worker's average earnings. *[Note: \$75 amount changed periodically by regulation pursuant to section 25 (4).]*

30(1)Where temporary partial disability results from the injury, the compensation shall be a periodic payment to the injured worker equal in amount to 75% of the difference between the average earnings of the worker before the injury and the average amount which he or she is earning or is able to earn in some suitable employment or business after the injury, and must be payable only so long as the disability lasts.

30(2)Where temporary partial disability results from the injury, the minimum compensation awarded must be calculated in the same manner as prescribed by section 29(2) for temporary total disability but to the extent only of the partial disability.

In addition to the policy, the Psychology Department has compiled a WCB Pain Glossary to help clarify confusion with respect to pain-related problems. It is anticipated that this Glossary will help assist in clarifying diagnostic criteria and diagnosis both within the WCB and externally (e.g. to injured workers). In this Glossary, for example, the Psychology Department asserts that the word "persistent pain" be employed in place of "chronic pain". It is also recognized that "persistent pain may exist in the absence of Chronic Pain Syndrome, but Chronic Pain Syndrome always presumes the presence of persistent pain" and that these two terms be kept distinct. Although the terminology presents some obstacles, the treatment is based on the demonstrated behaviour features.

The following behavioural features are considered descriptive of chronic pain syndrome. Although the first one listed is necessary for a diagnosis, it alone is not sufficient to diagnose chronic pain syndrome. The more numerous the remaining features, the more likely a diagnosis of chronic pain syndrome may be made.

- (1) Duration - persistent pain of six months or more duration. At three months an early diagnosis may be hypothesized, but six months is required for a diagnosis;
- (2) Marked pain expression and behaviour;
- (3) Continuing use of multiple medical services in pursuit of medical solutions;
- (4) Predominant reliance on medication and other substances for pain management;

- (5) Increased reliance on others in carrying out day-to-day social and health care responsibilities;
- (6) Marked alteration in mood and emotional functioning;
- (7) Pronounced and larger than medically expected reduction in physical activity;
- (8) Marked reductions in social, vocational, daily and recreational functioning.

With respect to the treatment of individuals with chronic pain, the Board indicates that various pain clinics are used such as the Columbia Rehabilitation Centre (Vancouver, British Columbia), the Vancouver Pain Clinic (Vancouver, British Columbia) and the Canmore Pain Clinic (Canmore, Alberta).

C. MANITOBA:

Presently, the Manitoba Workers Compensation Board (WCB) does not have a policy for handling chronic pain syndrome cases. It is, however, the subject of ongoing study.

In the absence of policy, the WCB has distributed guidelines to its case managers on this subject.

The guidelines make a distinction between chronic pain and chronic pain syndrome. Chronic pain is defined as pain that lasts for more than three months and is typically associated with physical illness. Chronic pain syndrome is classified using the following criteria:

- a complex group of symptoms where pain becomes the major focus and prime reason for disability;
- predominantly a psychological condition often with an underlying depression;
- treatment will focus on improving the patient's function and/or dealing with the depression.

The WCB will adjudicate chronic pain syndrome cases based on diagnostic criteria and by applying adjudicative principles. The case manager will determine eligibility for this syndrome by:

- establishing correct diagnosis through the Pain Management Unit;
- assessing work-relatedness ("arising out of and in the course of employment") and whether there is a causal connection; and
- determining if the diagnosis is disabling or results in a loss of earning capacity.

A worker's eligibility for benefits and services is not determined by the anticipated response to treatment. Eligibility and the worker's response to treatment are two separate issues.

Eligibility for benefits and services is reviewed on a continuous basis.

The acceptance of chronic pain syndrome results in a variety of benefits and services being offered to the worker. These benefits and services range from short-term psychological intervention to admission of the worker into a chronic pain management program with the worker receiving wage loss benefits. The WCB pays wage loss benefits when the pain is disabling or results in a loss of earning capacity. These benefits are not paid simply because the worker experiences pain. Further, the pain must be the result of a work-related injury.

Workers may be referred to either the Canmore or the Millard Rehabilitation Centers in Alberta for treatment.

In 1993, the WCB established a Pain Management Unit as part of its Healthcare Management Services Department. The Unit will identify workers with chronic pain syndrome and determine the most effective treatment plan for these individuals. The unit is comprised of a physician, a psychologist, and a registered nurse.

Referrals to this unit can be made by case managers, WCB medical advisors, and the worker's treating physician. Individuals referred to this Unit may include those who have some of the following:

- post-surgical rehabilitation;
- psychological intervention;
- negative changes in psycho-social functioning;
- excessive medication dependency;
- treatment ambiguity;
- depression; or
- extended duration beyond normal recovery norms.

In 1995, a consensus opinion on chronic pain syndrome was developed by the Healthcare Management Services Department. The opinion states that chronic pain syndrome has been sufficiently validated to acknowledge it as a distinct, identifiable, and potentially treatable clinical entity. The opinion discusses the etiology, causation, diagnostic criteria, and treatment of chronic pain syndrome.

In 2000, the Manitoba WCB conducted an evaluation of its referrals of injured workers to multidisciplinary treatment programs to determine if this practice has value for injured workers, employers and the WCB.

The study identified four key goals of these programs: increased employability, improved quality of life, reduced costs, and increased resolution of cases. It found that these programs achieved positive results in all of these areas. In addition, the study reported these results were achieved across a broad spectrum of outcome indicators.

D. NEW BRUNSWICK:

The Workplace Health and Safety Compensation Commission of New Brunswick currently does not have a formal policy with respect to chronic pain but is in the process of defining a policy. Each case of chronic pain is evaluated according to its own merits. Chronic pain is recognized as pain that exists six months or longer past the "normal" healing time of an injury. In isolation, chronic pain is not compensable even if it is the result of an acceptable work related accident. However, treatment of chronic pain may be a component of the overall rehabilitation for an acceptable work injury, and in this respect is compensable.

The New Brunswick Commission does have policies with respect to "fibromyalgia syndrome" (fibrositis), a chronic pain disorder of unknown etiology, and "myofascial pain syndrome", an acknowledged disease of the muscles. Fibromyalgia is considered to be a personal condition, not the result of trauma, and thus, is not acceptable by the N.B. WHSCC. Myofascial Pain Syndrome can result from acute trauma such as a work injury; therefore the Commission has taken responsibility for the original trauma to the muscle. The Commission has not taken responsibility for any perpetuating factors in the recovery.

Pain clinics exist in a few facilities in N.B., however, the only formally established pain program is the Pain Management Program at the Commission's Workers' Rehabilitation Centre. For the comprehensive management of chronic pain, injured workers are admitted to this program which provides chronic pain clients with assistance in coping with chronic pain, preparing for employment, increasing their level of functional activity and improving quality of life. Treatment is delivered by an interdisciplinary team consisting of a physician, psychologist, nurse, physiotherapist and an occupational therapist.

The components of treatment include:

- Education - (topics include coping skills, work simplification, proper posture and good body mechanisms, nutrition and stress management);
- Relaxation training;
- Group Therapy sessions;
- Functional and Vocational activities;
- Exercise Therapy and Home Program;
- Medication Reduction and Monitoring.

It is a six-week program and within that time frame a Functional Capacity Evaluation, as well as Vocational Aptitude Testing, may be performed to assist in the future management of the client.

E. NEWFOUNDLAND AND LABRADOR:

In August 1991, a Chronic Pain Policy was approved by the Workplace Health, Safety and Compensation Commission due to repeated requests for policy direction from its external appeal tribunal (WCAT). The policy statement asserts that "the Commission may accept entitlement for chronic pain disability when it results from a work related injury and there is sufficient credible subjective and objective evidence establishing the disability". According to this policy, chronic pain and chronic pain disability are defined as follows:

Chronic pain is pain whose characteristics are compatible with a compensable injury except that it persists for six or more months beyond the usual healing time for the injury. Chronic pain disability is the term used to describe the condition of a person whose chronic pain has resulted in marked life disruption.

Further, not all persistent pain cases are handled under this policy. The policy also states:

Where the chronic pain arises predominantly from psychological sources (other than the psychiatric diagnosis of post-traumatic stress disorder or conversion disorder) or undetected organic sources, the pain will be considered for compensation purposes under this chronic pain disability policy. However, not all persistent pain is dealt with by this policy. Where the pain is attributable predominantly to an organic cause or to a psychiatric condition of post-traumatic stress disorder or conversion disorder, the worker will be compensated pursuant to the Commission's policy on that organic or psychiatric condition.

Finally, the policy provides the following general information with respect to the manner in which chronic pain cases are to be handled:

1. For a worker to qualify for compensation for chronic pain disability a work related injury must have occurred and a claim for compensation for the injury submitted and accepted.
2. The Commission recognizes the consequences of chronic pain and chronic pain syndrome and encourages any necessary intervention to be given early in the course of treatment of the physical injury. If the condition interferes with the worker's vocational rehabilitation, appropriate care will be encouraged.
3. In rating any permanent functional impairment, once the injured worker has reached maximum medical recovery and has had adequate chronic pain intervention, the continued pain may, along with other symptoms that the injured worker states exists, be considered in addition to the objective signs of impairment that are found.
4. When injured workers cannot return to their regular work and cannot avail themselves of appropriate vocational programs the Commission may consider

chronic pain in the deeming process. If the evidence suggests that an injured worker could possibly be more active than he or she is, but because of the chronic pain has increased limitations, these may be judged proportionately and may result in a decrease in what the Commission would consider the injured worker capable of earning through the deeming process.

In summary, if a worker has received appropriate care, yet still experiences chronic pain, the pain symptoms may be considered, in addition to any other symptoms and the objective signs that exist, in rating the lump sum Permanent Functional Impairment benefit. Furthermore, when determining entitlement to extended earnings loss benefits, the effects of chronic pain may be considered.

According to the Commission, compensating for chronic pain is a challenging task, as it is difficult to ascertain entitlement to benefits based on the worker's reports of subjective symptoms. Despite the finding that the injury was insignificant and objective medical evidence lacking, frequently the worker's claim of total disability due to chronic pain results in a decision to pay full extended earnings loss benefits. The Commission believes this process of judging entitlement based on subjective responses, which cannot be administratively controlled, is costly and a threat to the financial viability of the compensation system.

This issue is continuously being reviewed and discussed by the Commission. Currently, the focus is on promoting early medical treatment and return to work plans with the goal of alleviating or eliminating the potential difficulties experienced by injured workers, which are associated with absence from the workplace for any period of time. The Commission stresses the importance to employers of accommodating injured workers back to work, as soon as possible, if not immediately.

Two types of treatment programs are currently utilized by this Commission. The Chronic Pain and Disability Management Centre (CPDMC) is a multidisciplinary team effort, which is a five week day-time hospital based program that admits approximately 45 chronic pain cases per year. A large number of the clients at the CPDMC are from outside the St. John's area. Secondly, a single clinical psychologist administers a program at the Behavioural Pain Management Centre (BPMC). This program admits approximately 25 cases per year from the St. John's area. Due to the inability of these programs to accommodate all of the referrals, many sufferers of chronic pain do not receive any chronic pain treatment at all. Further, some clients are rejected during pre-admission screening on the basis that they would not benefit from the behavioural approach to care at that particular time.

F. NORTHWEST TERRITORIES:

The WCB of the Northwest Territories and Nunavut does not have a policy on compensation of chronic pain or chronic pain disorders. At this time, it does not recognize these conditions as compensable. The Board has recently directed that a discussion paper on chronic pain be prepared.

The WCB understands chronic pain(s) to refer to pain that exists six or more months beyond the normal healing time of an injury. It is characterized by a cluster of symptoms which include the presence of chronic pain but also encompasses:

- marked pain behaviour out of proportion to any actual organic cause;
- search for medical solutions through use of multiple medical services; and,
- increasing reliance on medication and other substances for pain management and on other people for daily requirements.

If chronic pain or chronic pain disorders develop in conjunction with a compensable injury and delay or prevent an injured worker's recovery and resumption of former lifestyle, the WCB provides treatment at a pain clinic. Workers are referred to pain clinics located across Canada, depending upon the claimant's residence at the time of referral.

The worker receives temporary disability compensation, equivalent to wage loss, while in treatment. Once treatment has been completed and the medical condition resulting from a compensable injury has been stabilized, an assessment is done for a permanent disability pension, and temporary benefits cease.

Through timely diagnosis and appropriate application of an Early Intervention Program, the WCB aims to prevent the development and/or aggravation of chronic pain and chronic pain disorders. As these conditions are viewed as non-permanent and treatable, they are not eligible for a permanent disability award.

G. NOVA SCOTIA:

Compensation for chronic pain has changed significantly over the past four years. The Workers' Compensation Board of Nova Scotia approved its first formal policy and program in the spring of 1996 to prevent and manage chronic pain. The Board defines chronic pain, for the purposes of workers' compensation, as being pain:

i) continuing beyond the normal recovery time for the type of personal injury that precipitated, triggered or otherwise predated the pain, or

ii) disproportionate to the type of personal injury that precipitated, triggered or otherwise predated the pain;

and includes chronic pain syndrome, fibromyalgia, myofascial pain syndrome, and all other like or related conditions, but does not [emphasis added] include pain supported by significant, objective, physical findings at the site of the injury which indicate that the injury has not healed (Functional Restoration Program Regulations 96-207).

Chronic pain is multi-causal in nature and involves complex physical, emotional, psychological, behavioural, social and cultural factors. While chronic pain is real, it is different from acute pain, and no significant objective, physical findings are available to explain the presence of the pain. Pain (both acute and chronic) is personal and subjective. Chronic pain is often associated with soft tissue injuries such as strains, sprains, and contusions. Chronic pain is not continuing pain related to an injury that has not healed. It is also not related to an ongoing identifiable condition resulting from the injury that is supported by significant, objective physical findings (for example, a poorly healed fracture, nerve damage, or post-traumatic arthritis).

The Functional Restoration Program (FRP) was a two-phase program designed to help injured workers prevent and manage chronic pain so they may return to work and to a more active and healthy lifestyle. Where necessary, for a comprehensive approach to dealing with the condition, the FRP involved the family members of the injured worker.

Phase I of the FRP was offered as part of the WCB's Early Assistance case management process. It was intended for injured workers who identified pain as a major return-to-work barrier and who appeared to be at risk of developing chronic pain. This phase included pain-targeted services (which could include psychological services, work conditioning/hardening, counselling for medication usage, and sessions on work re-entry) in addition to the services available under case management. The intention in the first phase of pain-related services was to reduce the likelihood of, or prevent, a chronic pain situation developing. Phase I Program costs were capped at \$2,000.00 per client.

Phase II was offered to injured workers who were approved for return to work, however pain continued to be identified as a limiting factor. During this phase, the injured worker's family may be involved as an important part of the pain-management process. Injured workers eligible for this program received up to an additional four weeks of pain management services. This service was intended to provide clients with a final Board-supported opportunity to manage their pain. Phase II Program costs were capped at \$8,000.00 per client.

The FRP was authorized by a set of Regulations that took effect February 1, 1996. The same Regulations specify that, apart from the FRP, "no compensation is payable in connection with chronic pain."

In 1997 a Nova Scotia Court of Appeal decision ruled that the FRP Program could not be applied to workplace injuries occurring prior to February 1, 1996. As a result of this and subsequent Court decisions, chronic pain may be compensable for injuries during the "window period" of March 23, 1990 to January 31, 1996. In 1998, in response to the Court's interpretation of the Act and Regulations, the Board of Directors approved a series of Policies outlining eligibility for permanent benefits during the window period.

The policies affected workers who were injured between March 23, 1990 and January 31, 1996; developed chronic pain related to the injury; and as of April 18, 1997 had an open claim with the WCB

or an outstanding appeal with the WCB, WCAT or the Court of Appeal; and had not yet received a final decision on their claim.

Included in the Policies was an assessment tool called Marked Life Disruption Assessment (MLDA), utilized to assess the impact that chronic pain may have on an individual's life. This measurement tool was designed to be objective, consistent, reproducible and fair. The MLDA included a series of scientifically validated psychological tests and a structured interview with a registered psychologist specifically trained in this area. As a result of this process, a worker was noted as having mild, moderate, severe or extreme marked life disruption.

The WCB used the findings of the MLDA to establish the permanent medical impairment (PMI) of the injured worker where one did not already exist for the injury being compensated. For those affected injured workers who already had a PMI as a result of their work related accident, the WCB utilized their existing PMI. Existing PMI's were not to be "topped up" by the addition to the PMI scale. This addition was only to be used where there was not an existing PMI for the injury being compensated. The WCB then determined if the worker had experienced a compensable earnings loss as a result of his or her impairment. If a worker had not experienced an earnings loss as a result of the chronic pain, the worker was still entitled to a permanent impairment benefit (PIB). The WCB set up a Special Services Unit (SSU) to work with injured workers affected by the new policies.

Other concurrent activities were taking place during the establishment of the SSU. There were subsequent Court of Appeal decisions along with the Auditor General's *Audit of the Nova Scotia Workers' Compensation System* and the *Report of the Nova Scotia Select Committee on the Workers' Compensation Act* (November 1998). These activities culminated in legislative change. In April 1999, the Nova Scotia Legislature passed Bill 90, a Bill to Amend the Workers' Compensation Act. Bill 90 included several provisions relating to chronic pain. Essentially, these provisions confirmed that chronic pain was not compensable, except through the FRP Regulations and sections 10E and 10G of Bill 90.

Section 10E provided benefits to workers who were injured on or after March 23, 1990 and up to January 31, 1996, who developed chronic pain following a work injury, and who were on temporary benefits or in the appeals system as of November 25, 1998 (the date Bill 90 was introduced in the Legislature). Section 10E benefits included a 12.5% permanent impairment rating and a 50% apportioned Extended Earnings Replacement Benefit. Section G enabled the WCB to pay medical aid benefits to workers who met the criteria of section 10E.

The effect of the chronic pain provisions of Bill 90 was (a) to preclude the payment of compensation to workers with chronic pain who were injured prior to March 23, 1990, (b) to provide apportioned permanent benefits to certain workers injured on or after March 23, 1990 and up to January 31, 1996, and (c) confirm that the only compensation payable to workers with chronic pain injured on or after February 1, 1996 was through the FRP Regulations.

The WCB stopped referring workers for MLDA after April 1999 because the level of permanent medical impairment (PMI) under section 10E was set at 12.5% for all eligible workers. The 12.5% PMI for chronic pain was in addition to any PMI a worker might already possess. The WCB continued to determine whether a worker had a compensable loss of earnings as a result of the impairment. If a worker did not experience a loss of earnings as a result of the impairment, the worker was entitled to a PIB.

On January 31, 2000 the Nova Scotia Workers' Compensation Appeals Tribunal released three decisions on appeals of injured workers with chronic pain. In Decision No. 96-025-AD, the WCAT ruled that section 10E was discriminatory but found it was saved by section 1 of the *Charter of Rights and Freedoms*. In Decision No. 99-641-AD, the WCAT determined that sections 10B(b) and 10B(c) were unconstitutional, in that they precluded the payment of any benefits for chronic pain for workers injured before March 23, 1990. In Decision No. 98-077-AD, the WCAT decided that the FRP Regulations were unconstitutional.

The WCB has appealed Decision No. 99-641-AD and Decision No. 98-077-AD to the Nova Scotia Court of Appeal. The FRP Regulations are not being applied by the WCB at present, although pain management services continue to be offered to injured workers. The WCB has continued to pay benefits pursuant to section 10E. The Court of Appeal's decision is anticipated in the fall of 2000.

H. ONTARIO:

The Ontario Workplace Safety and Insurance Board's chronic pain policy defines *chronic pain* as "pain with characteristics compatible with work-related injury, except that it persists for six or more months beyond the usual healing time for the injury". The WSIB Clinical and Rehabilitation Services Department has formulated a chart enumerating "usual healing times" for various conditions. *Chronic pain disability* is a term "used to describe the condition of a person whose chronic pain has resulted in marked life disruption". Portions of the Board's policy are reproduced below:

The Board will accept entitlement for chronic pain disability (CPD) when it results from a work-related injury and there is sufficient credible subjective and objective evidence establishing the disability.

Not all claims involving persistent pain are adjudicated according to this policy. If the pain is predominantly attributable to an organic cause or to the psychiatric conditions of post-traumatic stress disorder or conversion disorder, the worker will be compensated pursuant to the Board's policy on that organic or psychiatric condition. If however, the chronic pain arises predominantly from psychological sources (other than post-traumatic stress disorder or conversion disorder) or undetected organic sources, the pain will be considered for compensation purposes under the CPD policy.

Compensation may be available for workers if the following conditions are satisfied. The policy also enumerates the evidence required to support these conditions.

- (1) A work-related injury occurred;
- (2) Chronic pain is caused by the injury;
- (3) The pain persists six or more months beyond the usual healing time for the injury. This six month period begins the date the healing process was expected to be complete;
- (4) The degree of pain is inconsistent with organic findings;
- (5) The chronic pain impairs earning capacity.

According to the Board, the procedure for dealing with individuals with chronic pain may vary, as procedures are the responsibility of individual offices. The Board has many adjudication units, however, despite this, the basic process is similar in claims where CPD may be applied. Ideally, nurse case managers review claim files 10 to 12 weeks post-injury to attempt to identify potential chronic pain cases. Those cases that exhibit signs of chronic pain behaviour can be referred to an external pain management program.

Once a claims adjudicator recognizes that a worker may be suffering from CPD, the worker's file is referred to the Medical Advisor (MA) to determine whether the required medical criteria are satisfied. The MA also reviews the worker's medical management to ensure the worker is receiving the appropriate medical investigations and treatment, and to ascertain the medical precautions for labour market re-entry. The worker usually receives temporary disability benefits during this time and may be involved in a medical and/or vocational rehabilitation program. If the medical criteria are met, the claims adjudicator determines whether the worker has a "marked life disruption". In the policy it is recognized that because pain is a subjective phenomenon, the only useful measure of disability or impairment in chronic pain cases is marked life disruption. As such, the adjudicator looks to behavioural changes as indicators of disability. Through an interview, the adjudicator assesses the extent that the worker's pain has affected: activities of daily living; vocational activity; physical and psychological functioning; as well as family and social relationships. A social worker's assessment may be required in certain cases to ascertain the degree of marked life disruption. Further, the policy states that there is "no particular requirement for the disruption to be either major or minor. The disruption in the worker's personal, occupational, social, *and* home life must be consistent [all four of these conditions must be satisfied], though the degree of disruption in each need not be identical".

If the claim has an accident date on or prior to January 1, 1990, a board physician and a board psychologist must examine the worker and provide a report to the adjudicator. The adjudicator then applies the description of the worker's "marked life disruption" against the board's "Psychotraumatic Behavioural Disorders Rating Schedule". The degree of "marked life disruption" will usually be reviewed by a manager, and the CPD award will be in accordance with the level of "marked life disruption".

If a claim has an accident date after January 1, 1990, according to s.47 of the Ontario *Workplace Safety and Insurance Act*, the board is to determine a worker's non-economic loss (NEL) by having regard to the NEL medical assessment and the prescribed rating schedule. Workers with CPD are assessed by psychiatrists appointed to the NEL roster of physicians. To ascertain the level of impairment of the worker, the NEL adjudicator considers: the medical assessment provided by the psychiatrist; Chapter 14 of the *AMA Guide*, "Mental and Behavioural Disorders"; in addition to the rating schedule outlined in the document entitled "Assessing Impairments Due to Mental and Behavioural Disorders Post-January 2, 1990 Claims".

There are numerous pain management programs available to injured workers across Ontario that differ in many respects. Some offer a multidisciplinary approach, while others are uni-modal or may involve two or more modalities. Further, while the majority of these are hospital based, others are available in physicians' private offices or attached to centres with sports clinics. Additionally, psychotherapeutic sessions, as an approach to pain management, are available through numerous psychologists across the province.

On January 1, 1998, The Workplace Safety and Insurance Act, 1997 came into force which permits limits to benefits for chronic pain in circumstances to be prescribed in a regulation. Following public consultation, the government directed the Board to commission an independent study of chronic pain. Injured workers with chronic pain continue to receive benefits pending the results of the study. In its August 2000 meeting, the WSIB's board of directors reviewed the results of a two year independent study into chronic pain and decided to:

- treat and underwrite chronic pain as it would any other workplace injury or illness;
- implement the consensus recommendations from the study concerning the treatment and management of chronic pain;
- continue to support research into the treatment and management of chronic pain; and
- review the issue in five years.

1. PRINCE EDWARD ISLAND:

On November 15, 1994, the Workers' Compensation Board of Prince Edward Island approved a policy for handling chronic pain cases. The Board at that time was committed to a preventive case management approach to the problem of chronic pain. It recognized chronic pain as the main factor leading to prolonged recovery in WCB claimants. They also recognize the devastating consequences of chronic pain, not only for the individual, but for the WCB and society at large. The Board makes note of the fact that the causes of chronic pain include activities of the health profession, the legal profession and, as well, the insurance system. It also notes that chronic pain is not a disease entity, but rather a condition or predicament. Chronic pain is, in itself, not medically measurable.

While it is important that injured workers receive fair financial compensation, the Board also recognizes that "financial rewards" can reinforce or aggravate the problem of chronic pain.

The Board does not provide financial compensation for chronic pain as such. They do compensate the injured worker during the recovery period up to the point of a "plateau in medical improvement". Benefits provided after the plateau point will be determined by considering the rate of medical impairment, functional ability, and wage loss.

In August, 1998, the Board requested that an Occupational Health Specialist enhance the Chronic Pain Policy and develop a practise protocol.

J. QUEBEC:

There is no formal policy for handling chronic pain cases in Quebec. The Commission de la santé et de la sécurité du travail suggests the reason for this is because the Commission is bound by the legislation contained in the *Industrial Accidents and Occupational Diseases Act*.¹⁶ This legislation provides that the Commission is bound by the diagnosis and conclusions of the doctor in charge of the worker. Relevant portions of this legislation are reproduced below:

Sec. 224. For the purpose of rendering a decision under this Act, and subject to section 224.1, the Commission is bound by the diagnosis and the other findings established by the physician in charge of the worker, respecting matters set out in subparagraphs 1 to 5 of the first paragraph of section 212.

Sec. 212. Subparagraphs 1 to 5:

- (1) the diagnosis;
- (2) the foreseeable date or time of consolidating the injury;
- (3) the nature, necessity, adequacy or duration of the administered or prescribed care or treatment;
- (4) the fact or degree of permanent physical or mental impairment of the worker;
- (5) the fact or the assessment of the worker's functional disability.

However, in the event of medical problems preventing a return to work, the CSST has devised new procedures based on close cooperation with the physician in charge.

Thus, it is often possible to propose a return-to-work solution respecting the worker's medical condition. The physician in charge is the most qualified to advise the CSST in this regard and to explain

to the worker that it is possible to return to work gradually while continuing certain treatments or adapting certain work activities.

In fact, rather than adopting a policy to mark out chronic pain, the CSST has elected to come to terms with this medical reality and seek a solution that maintains the employment link. The CSST does it in cooperation with the clients concerned (employer and worker) and by teaming up with the physician in charge of the worker.

K. SASKATCHEWAN:

The Saskatchewan Workers' Compensation Board does not have a specific policy with respect to chronic pain; rather they handle each case on its own merits. Accordingly, they have no formal or informal practice or procedure for dealing with chronic pain cases. However, the Saskatchewan Workers' Compensation Board does acknowledge that chronic pain exists, although there is no formal acknowledgement through permanent functional impairment.

L. YUKON:

On February 11, 1997, the Yukon Workers' Compensation Health and Safety Board approved a policy entitled *Treatment*. The *Treatment* policy replaces the *Chronic Pain and Chronic Pain Syndrome* policy which was revoked effective February 11, 1997. The new policy applies to all disabilities, regardless of accident date or governing legislation.

According to the Board's *Treatment* policy, workers may be entitled to treatment only "after a compensable work-related disability has occurred."

Treatment is only considered for chronic pain if chronic pain is hindering the recovery of the disabled worker. Treatment may be provided if it "expedites, or assists in the worker's recovery from a work-related disability", and will "reduce the degree of a worker's work-related permanent impairment".

A worker may receive treatment for up to six weeks. Loss of earnings benefits are paid while the worker is receiving treatment. Treatment is determined on a cost/benefit analysis.

The Board may refer workers for treatment to chronic pain clinics located outside the Yukon Territory such as the Columbia Rehabilitation Centre and the Vancouver Pain Clinic in Vancouver, British Columbia, and the Canmore Pain Clinic in Canmore, Alberta.

Summary of chronic pain approaches by jurisdiction

Aspect of Chronic Pain	Jurisdiction											
	A B	B C	M B	N B	N F	N W T/ N U	N S	O N	P E I	Q C	S K	Y K
<i>Does the jurisdiction define chronic pain?</i>	Y	Y	Y	N	Y	Y	Y	Y	N	N	N	N
<i>Is "6 months" included in the definition of chronic pain?</i>	Y	Y	N	N	Y	Y	N	Y	N	N	N	N
AB: 6 months beyond normal healing time;												
BC: Persistent pain of 6 months or more duration;												
MB: Definition refers to pain that lasts for more than three months;												
NF: 6 months beyond usual healing time for the injury;												
NW/NU: 6 months beyond normal healing time of an injury;												
ON: 6 months beyond normal healing time of an injury.												
<i>Is "beyond the normal time of healing" included in the jurisdiction's definition of chronic pain?</i>	Y	Y	N	N	Y	Y	*	Y	N	N	N	N
* NS: Beyond the normal recovery time;												
ON: The actual word used in the Ontario WSIB policy is "usual" rather than "normal" healing time.												
<i>Does the jurisdiction have a written formal policy re: chronic pain?</i>	Y	N	N	N	Y	N	Y	Y	Y	N	N	N
BC: A committee has been formed to develop policies regarding diagnosis, treatment and adjudication of chronic pain;												
MB: Studying issue – currently recognizes chronic pain syndrome;												
NB: In process of reviewing policies;												
NW/NU: Studying issue. Early intervention policy includes reference to chronic pain;												
NS: Yes, but the policy related to chronic pain is suspended pending the outcome of the N.S. Court of Appeal decisions;												
ON: Specifically, the policy relates to chronic pain disability;												
PEI: Currently enhancing existing policy;												

Aspect of Chronic Pain	Jurisdiction											
	A B	B C	M B	N B	N F	N W T/ N U	N S	O N	P E I	Q C	S K	Y K
SK: No formal policy, each case handled on own merits;												
YK: No single policy re: chronic pain but it is included in a Treatment Policy which replaced the Chronic Pain Policy.												
<i>Does the jurisdiction have a written procedure related to chronic pain?</i>	Y	N	N	N	N	N		Y	N	N	N	N
NS: Yes, but may change pending the outcome of the NS Court of Appeal decisions;												
YK: Other than procedure identified in the Treatment Policy.												

Aspect of Chronic Pain	A B	B C	M B	N B	N F	N W T/ N U	N S	O N	P E I	Q C	S K	Y K
<i>Is chronic pain compensable?</i>	Y	Y	* *	N	Y	N	*	Y	N	Y	* * *	N
BC: Chronic Pain is compensable where it is a result of a work-related personal injury or occupational disease;												
NB: Chronic pain is adjudicated as any other claim, although in most cases, "pain" is a secondary diagnosis to the description of injury or disease. There is a 6 week pain management program to assist workers with chronic pain;												
**MB: In Manitoba, chronic pain syndrome is compensable;												
NWT: Chronic pain is not a compensable condition however if it delays or prevents an injured worker's recovery and return to work, treatment at a pain clinic will be provided;												
*NS: From February 1, 1996 to January 31, 2000 (the date of the WCAT decisions currently under appeal at the NS Court of Appeal) temporary benefits as outlined in the FRP Regulations were provided; pain targeted services are provided for injuries that have occurred since February 1, 2000;												
PEI: chronic pain is recognized as the main factor leading to prolonged recovery in WCB claimants; compensation of the injured worker is provided during the recovery period up to the point of a plateau in medical improvement;												
QC: Chronic pain resulting from a physical injury, accepted as an occupational injury, as well as a psychological injury resulting from it, may extend the compensable duration of such injury;												
***SK: It could be compensable depending on the case itself. It can differ from case to case;												
YK: treatment is only considered for chronic pain if chronic pain is hindering the recovery of the disabled worker; a worker may receive treatment up to 6 weeks and loss of earnings benefits are paid while worker is receiving treatment.												
<i>Is treatment provided for workers with chronic pain?</i>	Y	Y	Y	Y	Y	Y	Y		Y	Y	*	Y
BC: Treatment may be provided by either internal or external treatment programs;												

Aspect of Chronic Pain	A B	B C	M B	N B	N F	N W T/ N U	N S	O N	P E I	Q C	S K	Y K
MB: In Manitoba, it is chronic pain syndrome;												
NS: Until January 31, 2000 injured workers received services under the FRP (the FRP is currently suspended pending the outcomes of the NS Court of Appeal decisions). In the interim, injured workers are receiving pain targeted services;												
QC: Yes, when the treatments are prescribed by the attending physician, or within the worker's rehabilitation;												
*SK: If it is seen as compensable by the WCB manager, treatment can be provided;												
YK: Only if the chronic pain hinders recovery from a compensable disability.												

Aspect of Chronic Pain	A B	B C	M B	N B	N F	N W T/ N U	N S	O N	P E I	Q C	S K	Y K
<i>Is a worker with chronic pain eligible for a permanent disability award?</i>	Y	Y	N	Y	N	N	*	Y	N	Y	N	N
AB: Permanent clinical impairment for CPS is assessed using the mental impairment portion of the assessment guide;												
BC: Permanent subjective complaints are recognized in calculating permanent impairment awards;												
*NS: Permanent benefits are provided for eligible workers injured between March 23, 1990 and January 31, 1996. On February 1, 1996 the FRP Regulations were introduced which provided temporary benefits for injured workers (the FRP is currently suspended pending the outcomes of the NS Court of Appeal decisions);												
ON: Workers who were injured before 1990 can receive permanent disability awards. For post-1990 injuries, the WSIB provides non-economic loss (NEL) benefits to compensate the permanent impairment and either future economic loss (FEL) benefits for workers injured between 1990 and 1999 or loss of earnings (LOE) benefits for post-1999 injuries to compensate the wage loss;												
QC: The compensation for bodily damages provides for a percentage for pain and loss of enjoyment of life, which increases with the increase in the percentage of the anatomo-physiological deficiency of the aesthetic damages. Furthermore, the chronic pain is taken into consideration when determining the functional limitations.												
<i>Does the jurisdiction record the number of injured workers with chronic pain (or percentage of all time-loss claims)?</i>	N	N	N	N	N	N	*	Y	N	N	N	N
AB: On an informal basis chronic pain claims have been manually tracked since 1994, however as this data may not be statistically reliable this data is not reported;												
N.B. There is no comparison of chronic pain claims to all time-loss claims. Separate stats are kept in pain management program;												
*NS: Statistics are kept only for injured workers who are												

Aspect of Chronic Pain	A B	B C	M B	N B	N F	N W T/ N U	N S	O N	P E I	Q C	S K	Y K
offered or participated in the FRP since its inception in February 1, 1996 and for those workers since February 1, 2000 who were offered or received pain targeted services.												

Aspect of Chronic Pain	A B	B C	M B	N B	N F	N W T/ N U	N S	O N	P E I	Q C	S K	Y K
<i>Does the jurisdiction record the number of injured workers who are treated for chronic pain?</i>	Y	Y	Y	N	Y	N	Y	Y	N	N	N	N
BC: Statistics are recorded for all workers treated for chronic pain by both external and internal pain programs;												
MB: For injured workers who are sent to the Canmore or Millard Centre;												
N.B. Within pain management unit of Rehabilitation Centre;												
Nfld: For those referred to the WHSCC chronic pain programs;												
NS: Yes for all injured workers who were offered or participated in the FRP since February 1, 1996 and those since February 1, 2000 who were offered or received pain targeted services.												
<i>Are return to work statistics recorded for injured workers with chronic pain?</i>	Y	Y	*	N	N	N	Y	Y	N	N	N	N
AB: Each facility providing pain management programs keeps outcome data for WCB claimants who have been treated at their facility;												
BC: Return-to-work statistics are recorded for all workers treated for chronic pain by both external and internal pain programs;												
*MB: On the claim file only;												
NB: Within pain management unit of Rehabilitation Centre;												
NS: Return to work statistics are recorded only for injured workers who were offered or participated in the FRP since February 1/96 or pain targeted services since February 1, 2000.												

JURISDICTIONAL CONTACT LIST

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Compensating for Chronic Pain - 2000

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